BASIC HEALTH SERVICES IN NEPAL

Priority Setting and Essential Health Interventions

Government of Nepal
Ministry of Health and Food Safety
Singhadurbar, Kathmandu

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मन्त्री
स्वास्थ्य तथा खाद्य स्वच्छता मन्त्रालय
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Message



The Constitution of Nepal guarantees every citizen the right to free basic health services. The Government of Nepal regards this guarantee as an obligation to be fulfilled in practice, in every municipality and for every household, including families in remote hill and mountain areas and communities that have long been left behind. Fulfilling this right is central to our national commitment to achieving universal health coverage by 2030.

Nepal has made commendable progress in maternal, newborn and child health and in the control of infectious diseases. However, our people's health needs are changing. Non-communicable diseases now account for about seven in every ten deaths, while households continue to bear more than half of current health expenditure through out-of-pocket payments, and public resources available for health remain limited. This makes it increasingly important to use available resources wisely and ensure that the most essential health services receive priority.

I am pleased to present this report, *Basic Health Services in Nepal: Priority Setting and Essential Health Interventions*, which marks an important milestone in Nepal's efforts to strengthen evidence-informed decision-making in the health sector. It documents the first systematic priority-setting exercise for the Basic Health Services Package, assessing a comprehensive range of essential health interventions, including clinical services, health promotion, and Ayurveda and Alternative Medicine, against six criteria endorsed by the Ministry. The findings indicate that most clinical interventions for which cost-effectiveness could be assessed offer very good value for money. They also highlight the need for a phased and predictable financing approach to ensure that the constitutional guarantee of basic health services is fully realised in practice.

The Ministry of Health and Food Safety will use this evidence as the technical foundation for the ongoing revision of the Basic Health Services Package and to align it more closely with planning, budgeting and service delivery at all three levels of government. Basic health services are delivered largely by local governments, with the support of provincial governments, and their success depends on effective coordination and collective efforts. I therefore call upon provincial and local governments, health workers, development partners, academia and civil society to work closely with the Ministry to ensure that the revised package reaches every citizen and that priority-setting becomes a regular and transparent practice of our health system rather than a one-time exercise.

I extend my sincere appreciation to the Secretary and the officials of the Ministry, the Steering Committee, the Technical Working Group, the departments, the provincial health authorities, and all who took part in the provincial and federal deliberations. I also thank the Bergen Centre for Ethics and Priority Setting in Health, University of Bergen, Norway, and the Nepal Health Economics Association for their valuable technical support. I am confident that this report will guide our decisions in the years ahead and help us build a health system that is equitable, efficient, and worthy of the trust of the Nepali people.

Neesha

Hon. Neesha Mehta
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Foreword



Nepal stands at an important point in its journey toward universal health coverage. As the health needs of our population continue to change, the growing burden of non-communicable diseases and limited public resources make it increasingly important to ensure that essential health services are prioritised based on need, affordability and feasibility.

This report, *Basic Health Services in Nepal: Priority Setting and Essential Health Interventions*, provides an important evidence base for the revision of Nepal's Basic Health Services Package (BHSP).

The findings carry clear messages for policy. Most clinical interventions assessed were found to be highly cost-effective, while health promotion measures addressing tobacco and alcohol use, nutrition, food fortification and awareness of non-communicable disease risk factors can prevent a large share of the preventable burden of disease. However, providing all proposed services at the intended level of coverage would require considerably more resources than are currently projected for basic health services. A phased approach, supported by predictable financing and better coordination between public budgets and health insurance, will therefore be important. The Ministry will use the findings of this report to inform the formal revision of the BHSP, together with the legal, financial and programmatic considerations. The Ministry remains committed to making priority setting a continuous process, closely linked to national planning and budgeting cycles.

I extend my sincere appreciation to the Steering Committee and the Technical Working Committee, as well as all concerned program divisions and centers, provincial health authorities, local governments, clinicians, programme managers, academics, development partners and stakeholders for their guidance, diligence and valuable inputs throughout the exercise. I also acknowledge the technical support of the Bergen Centre for Ethics and Priority Setting in Health, University of Bergen, Norway, and the Nepal Health Economics Association, whose expertise strengthened the rigour of the analysis. I very much appreciate the support from the Norad for this work through the University of Bergen.

I am confident that this report will serve as a valuable reference for policymakers, planners, programme managers and partners at the federal, provincial and local levels, and that it will help us make the choices before us in a manner that is fair, transparent and accountable to the people of Nepal.

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Dr. Bikash Devkota
Secretary
Ministry of Health and Food Safety
Government of Nepal

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Department of Global Public Health and Primary Care
Bergen Centre for Ethics and Priority Setting in Health (BCEPS)

Message

It has been a privilege for the Bergen Centre for Ethics and Priority Setting in Health (BCEPS), FairChoices Research, University of Bergen, to accompany the Ministry of Health and Food Safety (MoHFS) in this priority setting exercise for the Basic Health Services Package. The Constitution of Nepal promises free basic health services to every citizen. Honouring that promise within limited resources requires choices. The real question is not whether such choices are made, but whether they are made openly, on the basis of evidence, and with fairness to those whose needs are greatest. This report, *Basic Health Services in Nepal:Priority Setting and Essential Health Interventions*, shows how that can be done.

The Nepal exercise stands out for the leadership of the MoHFS. Every step, from the initial roadmap to validation of the final package, was decided through the Ministry's own Steering Committee and Technical Working Group and anchored in six priority-setting criteria that the Ministry had endorsed. A national technical team used the FairChoices Analytics Tool and local parameters to estimate Nepal-specific evidence for many of the 224 candidate health interventions and care pathways. As the data allowed, this team produced evidence against each criterion. That evidence covered health effects, cost-effectiveness, budget impact and the severity of the conditions addressed, and it was then examined in deliberations at provincial and federal levels. Quantitative evidence of this kind makes trade-offs explicit, which strengthens both the legitimacy of decisions and accountability for them. The results are encouraging. Most of the services that could be modelled offer excellent value for money, and a relatively small share of the additional cost delivers most of the health gain.

The report is equally candid that the full package cannot be afforded at once and must be phased as fiscal space grows. That honesty is itself an important contribution, because a package that is affordable and predictably financed will do more for the people of Nepal than one that promises everything. However, high coverage and high quality for all of the 131 health services that are assigned high priority in this revised BHS and planned to be scaled up in a first phase, is essential. The high-priority services cover RMNCH (n=48), communicable diseases (n=38), NCDs and disabilities (n=23), immunization (n=12), mental health (n=12), and emergency care (n=3). Universal and fair health coverage of these high-priority interventions will substantially improve health in Nepal.

For BCEPS, the work in Nepal has been one of mutual learning. The ten-step method for fair priority setting, first developed with Zanzibar, was adapted here to a federal system in which local governments deliver most basic health services. The lessons from Nepal will inform our work with ministries of health in other countries.

I sincerely thank the Honourable Minister, the Secretary, and the leadership and officials of the MoHFS, as well as the members of the Steering Committee and the Technical Working Group, for their trust, guidance and commitment. My thanks also go to the Department of Health Services and its divisions and centres, the Department of Ayurveda and Alternative Medicine, the provincial health authorities, and everyone who took part in the deliberations. I am especially grateful to the Nepal Health Economics Association, our in country partner, which carried much of the day-to-day coordination, data collection and analysis, and without which this exercise would not have been possible. I am also happy to welcome the Kathmandu University School of Medical Sciences, which will join the Nepal Health Economics Association as a partner in the next phase of the project. Further thanks go to The Norwegian Agency for Development Cooperation (Norad) for making funding available to BCEPS and for its continued engagement in project activities. I also gratefully acknowledge the Research Council of Norway for its Centres of Excellence grant and continued support to BCEPS as a Norwegian Centre of Excellence. BCEPS remains committed to supporting the Ministry as it revises the Basic Health Services Package and makes priority setting a regular,

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transparent function of the health system. I hope this report serves the Ministry well in the choices ahead and that Nepal's experience proves useful to other countries working towards universal health coverage. I look forward to working with the Ministry and our partners over the next five years to institutionalise evidence- and value-based priority setting in Nepal.



.....

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Acknowledgements

This report is the product of a priority setting exercise led by the Ministry of Health and Food Safety (MoHFS), Government of Nepal. The Ministry is grateful to the members of the Steering Committee and the Technical Working Committee, who guided the exercise from the choice of prioritization criteria to the validation of the final package and gave their time and judgement generously throughout.

We thank the divisions and centres of the Department of Health Services, in particular the Curative Service Division, which leads the revision of the basic health services, and the National Health Education, Information and Communication Centre, together with the Department of Ayurveda and Alternative Medicine and the Homeopathy Hospital. Their programme focal persons and thematic working groups shaped the list of interventions, reviewed the costing inputs and took part in the deliberations. We are equally grateful to the provincial ministries of health and the local governments of Karnali, Sudurpashchim and Lumbini provinces, and to everyone who took part in the provincial and federal deliberations and in the national validation meeting. Their practical knowledge of how services are delivered is reflected throughout this report.

Technical support was provided by the FairChoices team of the Bergen Centre for Ethics and Priority Setting in Health (BCEPS), University of Bergen, and by the Nepal Health Economics Association (NHEA) as its in country partner. We gratefully acknowledge the Norwegian Agency for Development Cooperation (Norad), whose funding to BCEPS made this support possible. We also thank the health development partners, independent experts, clinicians and academics who contributed evidence and advice, and the reviewers whose comments improved earlier drafts. The individuals who contributed to the exercise and to this report are listed in Annex 7.

About the report

Basic Health Services in Nepal: Priority Setting and Essential Health Interventions presents the results of a systematic, evidence informed priority setting exercise undertaken to support the efforts of the Government of Nepal to strengthen and improve the Basic Health Services Package (BHSP) using evidence, including economic analysis. The report is intended to inform a comprehensive and transparent review and update of the existing package, ensuring that it remains aligned with Nepal's evolving disease burden, population health needs and fiscal realities, and with the commitment of the Government of Nepal to achieving universal health coverage (UHC) by 2030.

The report documents the priority setting process led by the Ministry of Health and Food Safety (MoHFS), Government of Nepal, in collaboration with the Bergen Centre for Ethics and Priority Setting in Health (BCEPS), University of Bergen, Norway, with in country technical support from the Nepal Health Economics Association (NHEA). The process rested on sound analytical methods, explicit prioritization criteria, and extensive national and subnational consultations involving policymakers, programme managers, clinicians, technical experts and other stakeholders across the federal health system.

The report is organized in eight chapters. Chapter 1 sets out the rationale for priority setting and the design of the current BHSP, and Chapter 2 describes the health system context, including the burden of disease, the health care delivery system and health financing. Chapter 3 presents the methods: the principles and framework that guided the process, the identification and clustering of candidate interventions, the costing of interventions, the prioritization criteria, the modelling of cost effectiveness, the estimation of the budget envelope and budget impact, the deliberative processes and the validation of the results. Chapter 4 presents the results for the 300 candidate interventions: their unit costs and cost effectiveness, the outcomes of the deliberations and of the national validation, the final package in three priority groups, the prioritization of Health Promotion and Ayurveda and Alternative Medicine interventions, the delivery platforms, and the projected costs and budget impact. Chapter 5 considers how the results can inform the revision of the BHSP and how the revised package can be financed, Chapter 6 discusses its implementation and institutionalization and the health system reforms it requires, Chapter 7 sets out arrangements for monitoring and evaluation, and Chapter 8 summarizes the challenges and limitations of the exercise. The annexes provide the burden of disease by province, the governance structure of the exercise, the full list of candidate interventions with their costs, cost effectiveness and final priority group, a summary of the provincial deliberations, the prioritization matrix for Health Promotion interventions, the full results of the cost effectiveness analysis and the contributors to the report.

This version of the report presents the final results of the exercise. They draw on the final runs of the costing and cost effectiveness models, completed on 1 November 2026, and on the outcome of the federal deliberations and of the national validation meeting held on 2 November 2026, whose outcome was finalized on 4 November 2026. The clinical interventions are presented in three priority groups: a recommended priority package (Group 1), interventions that could be included as additional budget becomes available (Group 2), and interventions deferred for now (Group 3). Unless stated otherwise, costs are expressed in Nepalese rupees (NPR) at 2025 prices and cost effectiveness ratios in US dollars at 2024 prices, the price base of the cost effectiveness analysis. Fiscal years follow the Nepali calendar, with the corresponding Gregorian years given where helpful.

Beyond presenting results, the report serves as a technical reference to support policy dialogue and decision making on the revision and implementation of the BHSP. By making intervention definitions more explicit, clarifying intended service delivery platforms, and linking priorities with evidence on costs and coverage, the report aims to strengthen coherence between policy, planning, budgeting and service delivery. Overall, it is intended to support policymakers, health planners and partners in advancing a more equitable, efficient and sustainable health system in Nepal through transparent, evidence based priority setting.

List of abbreviations

ACS	Acute coronary syndrome	**LRI**	Lower respiratory infections
AFR	Accountability for reasonableness	**LTHP**	Long Term Health Plan
AHMIS	Ayurveda Health Management Information System	**M&E**	Monitoring and evaluation
AIDS	Acquired immunodeficiency syndrome	**MCDA**	Multicriteria decision analysis
AMR	Antimicrobial resistance	**MCER**	Marginal cost effectiveness ratio
ANC	Antenatal care	**MNCH**	Maternal, neonatal and child health
APH	Antepartum haemorrhage	**MoF**	Ministry of Finance
ASOM	Acute suppurative otitis media	**MoHFS**	Ministry of Health and Food Safety
AWPB	Annual work plan and budget	**MoHP**	Ministry of Health and Population
BCC	Behaviour change communication	**MR**	Measles rubella
BCEPS	Bergen Centre for Ethics and Priority Setting in Health	**MSS**	Minimum Service Standards
BCG	Bacille Calmette–Guérin (vaccine)	**NCDs**	Noncommunicable diseases
BEONC	Basic emergency obstetric and newborn care	**NDHS**	Nepal Demographic and Health Survey
BHS	Basic health services	**NGOs**	Nongovernmental organizations
BHSC	Basic health service centre	**NHEA**	Nepal Health Economics Association
BHSMS	Basic Health Services Monitoring System	**NHEICC**	National Health Education, Information and Communication Centre

BHSP	Basic Health Services Package	**NHFR**	National Health Facility Registry
BMI	Body mass index	**NHFS**	National Health Financing Strategy
BMS	Breastmilk substitutes	**NHSP**	Nepal Health Sector Programme
BoD	Burden of disease	**NHSS**	Nepal Health Sector Strategy
CBIMNCI	Community based integrated management of neonatal and childhood illness	**NHSSP**	Nepal Health Sector Strategic Plan
CEA	Cost effectiveness analysis	**NHWR**	National Health Workforce Registry
CHE	Current health expenditure	**NLSS**	Nepal Living Standards Survey
CI	Convergence index	**Norad**	Norwegian Agency for Development Cooperation
CIT	Citizen Investment Trust	**NPR**	Nepalese rupees
CKD	Chronic kidney disease	**NTDs**	Neglected tropical diseases
CMNN	Communicable, maternal, neonatal and nutritional (diseases)	**OA**	Osteoarthritis
CoFP	Counselling for family planning	**OAT**	Opioid agonist treatment
COPD	Chronic obstructive pulmonary disease	**OOP**	Out of pocket
COVID-19	Coronavirus disease 2019	**OOPS**	Out of pocket spending
CVD	Cardiovascular disease	**OPD**	Outpatient department
DALYs	Disability adjusted life years	**OPV**	Oral polio vaccine
DCP3	Disease Control Priorities, third edition	**PAMS**	Public Assets Management System
DDA	Department of Drug Administration	**PBMA**	Programme budgeting and marginal analysis

DHIS2	District Health Information Software 2
DM	Diabetes mellitus
DMPA	Depot medroxyprogesterone acetate
DoAAM	Department of Ayurveda and Alternative Medicine
DoHS	Department of Health Services
DPT-HepB-Hib	Diphtheria, pertussis and tetanus, hepatitis B and Haemophilus influenzae type b (pentavalent) vaccine
DR-TB	Drug resistant tuberculosis
e-LMIS	Electronic Logistics Management Information System
EDCD	Epidemiology and Disease Control Division
EHCP	Essential health care package
EMR	Electronic medical record
ENT	Ear, nose and throat
EPF	Employees Provident Fund
FCHVs	Female Community Health Volunteers
FMIS	Financial Management Information System
FY	Fiscal year
GAD	Generalized anxiety disorder
PCOD	Polycystic ovarian disease
PCOS	Polycystic ovary syndrome
PEN	Package of Essential Noncommunicable Disease Interventions
PFM	Public financial management
PHC	Primary health care
PHCC	Primary health care centre
PHSR	Public Health Service Regulation
PID	Pelvic inflammatory disease
PIVD	Prolapsed intervertebral disc
PLAMAHS	Planning, Logistics and Management Information System for Health Services
PLHIV	People living with HIV
PMTCT	Prevention of mother to child transmission of HIV
PPP	Public–private partnership
PPRD	Policy, Planning and Research Division
PTC	Primary trauma care
PTSD	Post traumatic stress disorder
PWID	People who inject drugs

GBD	Global Burden of Disease	**RA**	Rheumatoid arthritis (Annex 3); risk attributable burden (Annex 5)
GBV	Gender based violence	**RCCE**	Risk communication and community engagement
GDP	Gross domestic product	**RHD**	Rheumatic heart disease
GGHE-D	Domestic general government health expenditure	**RMNCAH-N**	Reproductive, maternal, newborn, child and adolescent health and nutrition
GI	Gastrointestinal	**ROI**	Return on investment
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit	**RR**	Relative risk
GUD	Genital ulcer disease	**SDGs**	Sustainable Development Goals
HAAD	Health adjusted age at death	**SMS**	Short message service
HALE	Healthy life expectancy	**SOPs**	Standard operating procedures
HBP	Health benefit package	**SSF**	Social Security Fund
HDPs	Health development partners	**STD**	Sexually transmitted disease
HEOC	Health Emergency Operation Centre	**STEPS**	WHO STEPwise approach to NCD risk factor surveillance
HIIS	Health Infrastructure Information System	**STIs**	Sexually transmitted infections
HIV	Human immunodeficiency virus	**STP**	Standard treatment protocol
HLY	Healthy life year	**SWAp**	Sector wide approach
HMIS	Health Management Information System	**TB**	Tuberculosis
HPV	Human papillomavirus	**TMIS**	Training Management Information System
HRH	Human resources for health	**TWC**	Technical Working Committee

HTA	Health technology assessment	**UHC**	Universal health coverage
HTN	Hypertension	**UiB**	University of Bergen
I$	International dollars	**UNFPA**	United Nations Population Fund
IBS	Irritable bowel syndrome	**UNICEF**	United Nations Children's Fund
IEC	Information, education and communication	**US$**	United States dollar
IHME	Institute for Health Metrics and Evaluation	**UTI**	Urinary tract infection
IHR	International Health Regulations	**VBDs**	Vector borne diseases
IMNCI	Integrated management of neonatal and childhood illness	**WASH**	Water, sanitation and hygiene
INGOs	International nongovernmental organizations	**WHO**	World Health Organization
IPV	Inactivated polio vaccine	**WHO-CHOICE**	WHO CHOosing Interventions that are Cost-Effective
IT	Information technology	**XDR**	Extensively drug resistant
IUCD	Intrauterine contraceptive device	**YLDs**	Years lived with disability
KUSMS	Kathmandu University School of Medical Sciences	**YLLs**	Years of life lost
LMICs	Low and middle income countries		

Executive summary

This report documents the first systematic and evidence informed priority setting exercise for the Basic Health Services Package (BHSP), led by the Ministry of Health and Food Safety (MoHFS) with technical support from the Bergen Centre for Ethics and Priority Setting in Health (BCEPS), University of Bergen, and the Nepal Health Economics Association (NHEA). The package guaranteed under Article 35 of the Constitution is comprehensive. It was not built on explicit choices between interventions and has never been costed, and the resources to deliver it are limited.

A desk review and extensive consultations produced 300 candidate interventions: 204 clinical interventions in six clusters, costed as 224 care pathways, 60 Ayurveda and Alternative Medicine interventions and 36 Health Promotion interventions. Six criteria endorsed by the MoHFS guided the choices. Deliberations were held in three provinces and at the federal level, and the results were confirmed at a national validation meeting on 2 November 2026.

Most of the services that could be modelled are excellent value for money. Cost effectiveness could be estimated for 81 of the 204 clinical interventions (92 pathways), and 68 of them cost less than half of GDP per capita per healthy life year gained; this band accounts for 95% of the modelled health gain for under half of the incremental cost. Pathways below this line were included by rule, as were family planning and other programme commitments for which no health gain is modelled. The remaining pathways, those with higher ratios and those without a cost effectiveness estimate, were placed in priority groups by consensus, on their budget impact and the qualitative criteria.

Group 1, the recommended priority package, contains 131 clinical pathways. They are to be delivered with all 36 Health Promotion and all 60 Ayurveda and Alternative Medicine interventions. Group 2 (82 pathways) can be added as the budget grows, and Group 3 (11) is deferred; no pathway was excluded. Conditions on how they are delivered, such as tiered chronic care or stabilization and referral, apply to 25 pathways. The groups set the pace of financing and do not reduce the constitutional guarantee of free basic health services.

At current coverage, the 224 candidate pathways (of the 204 clinical interventions) cost NPR 22.4 billion a year at 2025 prices, about NPR 760 per person. At target coverage the cost would be NPR 65.8 billion, about NPR 2,220 per person, of which 34% maintains current coverage, 19% expands the coverage of services already provided and 47% pays for additional tests, medicines and procedures not yet part of current practice.

Group 1 accounts for NPR 44.2 billion a year at target. The budget envelope for basic health services was NPR 36.6 billion in FY 2083/84, 37.9% of the health budget, and is projected at NPR 214.8 billion over FY 2084/85 to 2088/89. Group 1 would cost NPR 204.4 billion over these five years, 95% of the envelope. Its annual cost, however, exceeds the envelope from FY 2087/88, so sustaining it at full target coverage requires the envelope to grow faster than projected. Adding Group 2 raises the cost to NPR 270.7 billion, about a quarter above the envelope. The package must therefore be phased: Group 1 first, Group 2 as fiscal space grows.

Financing should be predictable as well as adequate. The report proposes a protected minimum allocation for basic health services; conditional grant guidelines aligned with the package; a rising health share of the national budget, supported by higher tobacco and alcohol excise; a costed transition from external financing; and a joint review with the health insurance benefit package that keeps every BHSP service free at the point of use.

The estimates have limits. Ratios for interventions that deliver only part of the

modelled care, such as screening and referral, are optimistic. Unit costs are normative national averages, coverage targets often rest on expert judgement, Health Promotion was not costed, and the comparison with the envelope is indicative.

Monitoring would build on the Basic Health Services Monitoring System and routine information systems. Indicators would be aligned to the prioritized interventions and their delivery platforms, with the baseline and target coverage established in this exercise as the starting point.

The validated package will guide the formal revision of the BHSP through an amendment to the Public Health Service Regulation, supported by the legal, financial, institutional and programmatic arrangements that the MoHFS considers necessary for effective implementation. Priority setting will continue as a regular function linked to planning and budgeting.

Contents

1 Introduction 2
1.1 Background 2
1.2 Priority setting in health care 3
1.3 Priority setting practices in Nepal 4
1.4 Basic health services and the package design 6
1.5 Objectives 8

2 Health System Context 10
2.1 Population health status 10
2.1.1 Life expectancy 10
2.1.2 Disease burden by cause 10
2.1.3 Deaths 10
2.1.4 Disability adjusted life years 11
2.1.5 Burden of disease at subnational level 11
2.2 Health care delivery system 14
2.2.1 Structure and functioning of the health care delivery system 15
2.2.2 Structural issues and potential in the federal system 17
2.3 Health financing 18
2.3.1 Sources and trends in health financing 19
2.3.2 Health care financing mechanism 21
2.3.3 Financial risk and out of pocket expenditure 22
2.3.4 Current fiscal space for health 23
2.3.5 Public financial management and resource allocation 24

3 Methods and Analytical Framework 30
3.1 Principles of priority setting 30
3.2 Framework for priority setting 30
3.3 Mapping and contextualization of health interventions 32
3.3.1 Desk review 33
3.3.2 Stakeholder consultation 33
3.3.3 Clustering of the interventions and removal of duplication 34
3.4 Costing of interventions 36
3.4.1 Approach and scope 36
3.4.2 Estimation of unit costs 36
3.4.3 Population in need, coverage and annual cost 37
3.4.4 Assumptions and sensitivity analysis 38
3.4.5 Inputs to the cost effectiveness analysis 39
3.4.6 Estimation of budget impact 41
3.5 Prioritization of interventions 41
3.5.1 Development of prioritization criteria 42

3.5.2 Prioritization criteria 43
3.5.3 Process for prioritization of interventions 47
3.5.4 Validation of results 57

4 Prioritized Interventions For The Basic Health Services Package 60

4.1 From candidate interventions to the final package 60
4.2 Unit costs and cost effectiveness 61
4.2.1 Evidence available by category 61
4.2.2 Unit costs of interventions 62
4.2.3 Ranking of clinical interventions by cost per healthy life year gained 64
4.3 Outcomes of deliberation 69
4.3.1 Provincial deliberations 69
4.3.2 Federal deliberations and final selection 70
4.3.3 National validation and the final package 71
4.4 Health promotion and Ayurveda and alternative medicine interventions 73
4.4.1 Health promotion 74
4.4.2 Ayurveda and alternative medicine 75
4.5 Delivery platforms for the package 77
4.6 Costs and budget impact 78
4.6.1 Baseline and projected costs to 2031 78
4.6.2 Budget impact and affordability 82

5 Revising And Financing The Basic Health Services Package 86

5.1 From priority setting to revision of the BHSP 86
5.2 Resource requirements of the prioritized package 88
5.3 Available resources and the financing gap 91
5.4 Expanding fiscal space for basic health services 93
5.4.1 Generating additional resources for health 93
5.4.2 Obtaining more health from existing resources 94
5.5 Aligning financing channels: basic health services and health insurance 96
5.6 Ensuring predictable financing for basic health services at the local level 98
5.7 Financing health promotion and Ayurveda and alternative medicine 100
5.8 The way forward: phasing the package to 2030 101

6 Implementation Of The Revised Basic Health Services Package And Health System Reforms 104

6.1 Implementation of the revised basic health services package 104
6.2 Institutionalization and integration 105
6.2.1 Operationalization support structure at the federal level 106
6.2.2 Priority setting as a continuous process 107
6.3 Health system reforms for basic health services 108

6.3.1 Leadership and governance 108
6.3.2 Service delivery and referral systems 108
6.3.3 Essential medicines, diagnostics, equipment and infrastructure 111
6.3.4 Strengthening health workforce capacity 112
6.3.5 Health information systems, digital health and data for equity 113
6.3.6 Accountability and demand side readiness 114
6.3.7 Monitoring, evaluation and supervision 114
6.4 Preparing the health system to sustain basic health services during emergencies 114
6.4.1 Outbreaks, disasters and basic health services 114
6.4.2 Keeping basic health services running 114
6.4.3 Directions for wider preparedness 115
6.5 Roadmap: responsibilities and sequencing 115

7 Monitoring and Evaluation of the Basic Health Services Package 120

7.1 Building on existing monitoring arrangements 120
7.2 Aligning indicators with the revised package 120
7.3 Regular monitoring through routine information systems 121
7.4 Periodic surveys and evaluation 122
7.5 Using monitoring results to review the package 123

8 Challenges And Limitations 126

8.1 Challenges 126
8.2 Limitations 126

References 130

Annexes 136

Annex 1: Burden of disease by province 136
Annex 2: Governance structure 138
Annex 3: List of interventions with costs, cost effectiveness and final priority group 139
Annex 3.1: Components of bundled interventions 179
Annex 4: Summary from provincial deliberations 182
Annex 5: Prioritization matrix for Health Promotion interventions 184
Annex 6: Cost effectiveness results and link to Nepal interventions 190
Annex 7: Contributors to the report 198

List of Tables

Table 1:	Categories of services within basic health services, as defined in the Public Health Service Regulation, 2077 (2020)	7
Table 2:	Key statistics on health expenditure in Nepal, 2005–2023	20
Table 3:	Federal health budget as a share of the national budget, FY 2080/81 to 2083/84	23
Table 4:	Health budget by level of implementation, FY 2080/81 to 2083/84 (NPR million)	26
Table 5:	Application of the ten step method for priority setting in Nepal	31
Table 6:	Candidate interventions by category and cluster	35
Table 7:	Calculation and valuation of unit costs for clinical interventions	37
Table 8:	Main assumptions of the costing	38
Table 9:	Definitions of the budget envelopes	48
Table 10:	Streams for the final selection of clinical interventions	55
Table 11:	Evidence available for the candidate interventions, by category and evidence group	62
Table 12:	Unit costs of clinical pathways by cluster (NPR per case, 2025 prices)	63
Table 13:	Clinical pathways by cluster and cost effectiveness band (number of pathways)	67
Table 14:	Nepal interventions that deliver part of a modelled intervention	67
Table 15:	Clinical pathways by stream (final estimates)	71
Table 16:	Final clinical package by group	72
Table 17:	Final clinical package by group and cluster (pathways; NPR billion a year at target)	72
Table 18:	Prioritized Health Promotion interventions by theme	74
Table 19:	Prioritized Ayurveda and Alternative Medicine interventions by subcluster and delivery platform	76
Table 20:	Clinical interventions in the final package by cluster and delivery platform (number of interventions)	77
Table 21:	Annual cost of the candidate clinical pathways by component, 2026 to 2031 (NPR million)	79
Table 22:	Annual cost of the candidate clinical pathways by cluster (NPR million)	81
Table 23:	Cost of the candidate clinical pathways by cost effectiveness band (NPR million)	81
Table 24:	Projected budget envelopes, FY 2084/85 to 2088/89 (NPR million)	82
Table 25:	Resource requirement of the final package and the projected BHS envelope, FY 2084/85 to 2088/89 (NPR million)	84

Table 26:	The current and the proposed basic health services package compared	87
Table 27:	Projected budget envelope, resource requirement and financing gap for the final package, FY 2084/85 to 2088/89 (NPR million)	92
Table 28:	Short term, medium term and long term strategies for harmonization of health financing schemes	98
Table 29:	Health allocations to local levels by component, FY 2080/81 to 2083/84 (NPR million)	99
Table 30:	Phasing of financing measures for the revised BHSP	102
Table 31:	Group 1 pathways by what their delivery depends on	109
Table 32:	Roadmap for implementing the revised BHSP: responsibilities, prerequisites, timing and milestones	116
Table 33:	Illustrative monitoring domains, routine data sources and complementary sources for the revised BHSP	122
Table 34:	Burden of disease by province, 2023	136
Table 35:	Composition of the Steering Committee	138
Table 36:	Composition of the Technical Working Committee	138
Table 37:	Interventions with delivery platform, costs, cost effectiveness, stream and final priority group	139
Table 38:	Components of the bundled interventions in Cluster 2 (RMNCAH-N)	179
Table 39:	Comparative summary of province level feasibility appraisal findings	182
Table 40:	Intervention level prioritization matrix for Health Promotion (Cluster 8)	184
Table 41:	Cost per healthy life year gained	190
Table 42:	Interventions without a modelled health gain	197

List of Figures

Figure 1:	Health sector priorities and priority groups in different policy documents	5
Figure 2:	Life expectancy in Nepal, 1990–2023	11
Figure 3:	Burden of disease in Nepal, 1990 and 2023	12
Figure 4:	Proportion of deaths and DALYs due to different causes, 1990 and 2023	13
Figure 5:	Structure and functions of the federal health system in Nepal	16
Figure 6:	Distribution of current health expenditure by source	19
Figure 7:	Health financing flow of Nepal	22
Figure 8:	Health expenditure as a proportion of total expenditure at federal level	24
Figure 9:	Expenditure share among the three tiers of government	25
Figure 10:	Transfers from the federal government to local governments	26
Figure 11:	Principles of health benefit packages	31
Figure 12:	Process adopted in development of prioritization criteria	42
Figure 13:	Criteria for prioritization of health interventions in Nepal	43
Figure 14:	Prioritization process for clinical interventions with cost effectiveness data	54
Figure 15:	From candidate interventions to the final package	61
Figure 16:	Cost per healthy life year gained for Nepal interventions with a full match (US$, 2024 prices, log scale)	66
Figure 17:	The UHC cube: what the full candidate package would buy	79
Figure 18:	Annual cost of the candidate clinical pathways by component, the cost of Group 1 and the projected BHS envelope, 2026 to 2031 (NPR billion, nominal)	80
Figure 19:	Distribution of the health budget by tier of government, FY 2080/81 to 2083/84 (2023/24 to 2026/27)	91
Figure 20:	Harmonization of fragmented financing schemes	97
Figure 21:	Operationalization support structure at the federal level and its links with provinces and local levels	107
Figure 22:	Integrated health management information system	121

1
Introduction

1 Introduction

1.1 Background

Priority setting for essential health services is a fundamental policy necessity in low and middle income countries (LMICs), where health needs are vast but resources remain severely constrained. Governments in such settings face a persistent imbalance between the demand for health care and the financial, human and institutional capacity available to deliver it. In the absence of explicit prioritization, resource allocation often becomes fragmented, inefficient, and driven by historical patterns or political pressures rather than by population health needs, cost effectiveness, equity and other explicit criteria.[1,2]

At the core of this challenge lies the principle of scarcity and opportunity cost: allocating resources to one intervention inevitably means forgoing another. This choice is particularly consequential in LMICs, where even small misallocations can lead to substantial losses in health outcomes. Systematic priority setting helps to ensure that limited resources are directed towards interventions that generate the greatest health gains, such as reductions in mortality, morbidity and financial hardship, thereby maximizing overall social welfare. Because health systems cannot fund all possible interventions, prioritization enables decision makers to allocate resources to those that yield the highest health returns relative to cost, improving overall system efficiency.[3,4]

Priority setting is also essential for the progressive realization of UHC. LMICs cannot immediately provide all services to all people; instead, they must define a feasible and evidence based package of essential health services that can be expanded over time. Priority setting provides both the analytical and the ethical foundation for determining which interventions should be included in such packages, balancing considerations of cost, effectiveness and fairness.[1,2]

Equity considerations further reinforce the importance of structured priority setting. Health systems in LMICs often exhibit significant disparities in access and outcomes across income groups, geographical regions and social categories. Without deliberate prioritization, marginalized populations are at risk of being excluded from essential services. A well designed priority setting framework allows policymakers to incorporate equity objectives explicitly, ensuring that resources are directed towards interventions that benefit the most vulnerable and reduce health inequalities.[1,3] In Nepal, these disparities are shaped strongly by geography: people living in remote hill and high altitude mountain areas face long travel times to health facilities, scattered settlements and seasonal disruption of roads and trails, which raise the cost of delivering basic health services and make them harder to reach. The design and delivery of the package therefore need to take these challenges into account explicitly.

In addition, the use of explicit criteria, such as cost effectiveness, disease burden and equity, enhances transparency and accountability in decision making. This reduces arbitrariness, strengthens the legitimacy of policy choices and builds public trust in the health system. Priority setting contributes to efficient planning and

long term sustainability by aligning limited resources with high impact interventions, thereby improving health outcomes per unit of expenditure and supporting more resilient health systems that are capable of addressing both current and emerging challenges.[4]

International experience shows that many countries facing similar constraints have addressed these challenges through the systematic design or revision of health benefit packages (HBPs), using explicit priority setting processes that consider cost effectiveness, disease burden, equity and contextual feasibility.[5,6] These experiences demonstrate that explicit priority setting is not a one time exercise but a continuous policy function that supports both efficiency and fairness in health system decision making (Section 1.2).

In Nepal, basic health services (BHS) represent the nationally defined form of essential health services and constitute the core service entitlement guaranteed to the population (Section 1.4). The BHSP is the main HBP currently implemented in Nepal; in addition, a number of other state funded programmes, including vertical programmes, cover a wide array of the health needs of the population.

Priority setting for basic health services also needs to be linked to the way the health system is financed and organized. In Nepal, out of pocket payments make up 59.4% of current health expenditure, while domestic government health spending is about 1.9% of gross domestic product, so households bear a large share of the cost of care, much of it paid to private providers outside any defined entitlement, and remain exposed to financial hardship despite the constitutional entitlement to free BHS (Section 2.3). The interventions in the package can also reach people only if health facilities have the health workers, medicines, diagnostics and referral links needed to deliver them, and if the federal, provincial and local governments that share responsibility for delivery have the capacity and predictable resources to do so (Section 2.2). For this reason, the exercise links the prioritization of interventions with their costs, budget impact, financing options and implementation requirements, so that the revised package can be financed and delivered rather than remaining an entitlement on paper.

1.2 Priority setting in health care

Priority setting is a core component of health policy that guides how limited resources are allocated across competing health needs. It occurs at clinical, organizational and population levels and requires balancing equity and efficiency to decide which services should be funded, for whom, and at what level.[7] A fair, transparent and evidence informed process ensures that essential health interventions are systematically identified and financed.

Ethical theories such as utilitarianism (health maximization), egalitarianism (focus on equality), prioritarianism (balance between health maximization and priority to the worst off), sufficientarianism (everyone has health above a threshold) and rights based approaches offer different value perspectives, but each also comes with limitations.[8] Priority setting methods draw on these values and on available evidence to guide decisions in a systematic, fair and transparent way. Common approaches for operationalizing priority setting in health care include programme budgeting and marginal analysis (PBMA), cost effectiveness analysis (CEA), burden of disease (BoD) analysis,

multicriteria decision analysis (MCDA), health technology assessment (HTA), and frameworks such as evidence informed deliberative processes and accountability for reasonableness (AFR). Used together, these approaches support priority setting decisions that are sound and defensible.

International experience shows diverse practices. High income countries such as the United Kingdom and Norway have institutionalized systems with strong transparency and appeals mechanisms,[6] while LMICs such as Ethiopia, Tanzania (including Zanzibar), Ghana, India and Pakistan have adopted structured processes for defining HBPs using criteria such as cost effectiveness, disease burden, equity, feasibility and financial protection, among others.[5] More recently, Kyrgyzstan revised its State-Guaranteed Benefits Programme over 2023–2025 through an evidence informed deliberative process that applied the WHO UHC Compendium to define services and estimate their costs.[9] Successful implementation of essential health care packages globally has relied on four prerequisites: high level political commitment, sustainable financing, health system readiness and institutionalization of the priority setting process.[10]

1.3 Priority setting practices in Nepal

In practice, priority setting in Nepal's health sector has historically been guided by national development plans, periodic health sector strategies and programme specific initiatives. Across different policy documents, priority setting criteria have consistently included considerations such as burden of disease, population need, service coverage, access and availability of services. Over time, there has been a gradual shift towards incorporating additional dimensions such as equity and efficiency, particularly in more recent policy frameworks.

A review of key health policy documents, from the First Long Term Health Plan (1975–1990) through successive health sector programmes and strategies up to the Nepal Health Sector Strategic Plan (NHSSP) 2023–2030[11] and the National Health Financing Strategy (NHFS) 2023–2033,[12] shows an evolution in how priorities are defined and articulated (Figure 1). Early policy documents were largely focused on expanding service availability and building health infrastructure. In contrast, more recent strategies increasingly emphasize UHC, financial protection, system strengthening and improved governance.

However, across the twelve or so major policy documents reviewed, a common pattern emerges: priority setting has often been interpreted as expanding and listing a comprehensive package of services rather than explicitly selecting among competing priorities. This "comprehensiveness approach" reflects a policy intention to demonstrate that essential services are available to all citizens. While this is important from an equity and political commitment perspective, it has often come at the expense of explicit prioritization, in which the difficult choices between interventions are made clear.

Recent policy directions, particularly under the NHSSP and NHFS, explicitly recognize these challenges. These strategies emphasize progressive realization of UHC, efficient use of resources and strengthened governance. They also highlight the need for better alignment between priorities, financing mechanisms and health system constraints. Priority setting is thus increasingly viewed

not just as a technical exercise but as a strategic tool that links national health goals, equity principles, evidence and fiscal realities.

From the 1990 Constitution (developed after the fall of the partyless Panchayat regime) to the 2015 Constitution (enacted after the abolition of the monarchy), health has remained a fundamental concern in Nepal, anchored in principles of equality, inclusion and social justice. A review of health policies and plans across these political periods reveals a gradual transition from infrastructure development and essential service provision towards rights based, inclusive and system strengthening approaches. Maternal and child health, communicable disease control and treatment of common injuries feature prominently in all policy documents, while NCDs, mental health and urban health have received policy attention more recently. Similarly, the commitment to targeting marginalized groups, women, children, Dalits and economically disadvantaged populations has persisted across decades, reflecting a sustained equity orientation.



Figure 1: Health sector priorities and priority groups in different policy documents

Note: LTHP: Long Term Health Plan; NHFS: National Health Financing Strategy; NHSP: Nepal Health Sector Programme; NHSS: Nepal Health Sector Strategy; NHSSP: Nepal Health Sector Strategic Plan; EHCP: essential health care package; GBV: gender based violence.

Nevertheless, one of the major gaps in Nepal's current practice remains the limited and inconsistent use of systematic, evidence based priority setting tools and processes. Although data on service utilization and health outcomes are available, their integration into decision making is often weak. Economic evaluation methods, such as cost effectiveness analysis and allocative efficiency assessment, are not routinely institutionalized, leading to potential mismatches between resource allocation and actual health gains.

Strengthening priority setting practices is therefore essential for Nepal's health system. A more explicit and evidence informed approach would help to reduce fragmentation, improve coordination across federal, provincial and local levels, and ensure that limited resources are directed towards interventions that generate the greatest health impact while maintaining an equitable distribution. Over time, this would support the development of a more coherent, efficient and equitable health system that is capable of delivering essential services while protecting households from financial hardship.

1.4 Basic health services and the package design

BHS in Nepal are grounded in a strong constitutional foundation: Article 35 of the Constitution of Nepal (2015) guarantees every citizen the right to free BHS and protection from being deprived of emergency care.[13] From a priority setting perspective, this constitutional mandate is highly significant because it transforms health from a discretionary service into a legally binding entitlement. It establishes a normative framework in which the State is obliged not only to provide services but also to define what constitutes "basic health care". The BHSP thus becomes the practical expression of national priority setting.

The formal definition of BHS under the Public Health Service Act (2018)[14] and the Public Health Service Regulation (2020)[15] represents a major institutional step in explicit priority setting. These legal instruments define not only the service package but also the responsibilities of federal, provincial and local governments, with local governments primarily responsible for implementation. This reflects a shift from implicit priority setting towards explicit priority setting through a defined benefit package.

In practice, the delivery of BHS is supported by a decentralized network of basic hospitals (which include the former primary health care centres), basic health service centres (which include the former health posts), urban health centres, community health units and community platforms such as outreach clinics and Female Community Health Volunteers. These facilities provide a wide range of health care services, particularly in maternal and child health, nutrition, immunization and the management of common diseases. From a priority setting perspective, this decentralized structure reflects an attempt to operationalize equity by bringing services closer to underserved populations. However, decentralization also introduces variation in implementation capacity, which can affect how priorities are translated into actual service delivery.

Table 1: Categories of services within basic health services, as defined in the Public Health Service Regulation, 2077 (2020)

S.N.	Categories of services
1	Immunization
2	Integrated management of newborn and childhood illnesses; nutrition services; pregnancy, labour and delivery services; maternal, newborn and child health services, such as family planning, abortion and reproductive health
3	Services related to infectious diseases
4	Services related to NCDs and physical disability: hypertension, diabetes mellitus, chronic obstructive pulmonary disease (COPD) and asthma, musculoskeletal pain, acid peptic diseases, eye problems, ear problems, oral health problems and disability
5	Mental illness services: common mental health problems, alcohol and substance abuse
6	Geriatric health services
7	General emergency services: injuries and wounds, management of common emergency conditions, eye, ear, nose and throat (ENT) related common emergencies, snakebite
8	Health promotion
9	Ayurveda and other accredited alternative health services: Ayurveda and homeopathy
10	Other services prescribed by the Government by notification in the Nepal Gazette

Source: Public Health Service Regulation, 2077 (2020).[15]

From a design perspective, the BHSP is comprehensive, covering promotive, preventive, diagnostic, curative and rehabilitative services. It includes immunization, integrated management of neonatal and childhood illness (IMNCI), nutrition, maternal, neonatal and child health (MNCH) services (including antenatal care, delivery, family planning, abortion and reproductive health), infectious disease control, NCDs, mental health, geriatrics, emergency care, health promotion and traditional medicine systems such as Ayurveda (Table 1).

This design choice involves a difficult policy balance. On the one hand, providing a broad package free of cost strengthens equity, political acceptability and alignment with constitutional rights. On the other hand, offering a wide range of services without explicit prioritization places significant pressure on limited public resources, dilutes funding across many interventions and can reduce the quality, efficiency and health impact of services. In such a context, implicit rationing may occur through shortages, uneven availability or variation in service quality across regions. The Procedure for Operation of Basic Health Services, 2022,[16] provides additional standards for infrastructure, quality, waste management and patient rights; these strengthen implementation capacity but do not resolve the core priority setting challenge of optimizing resource allocation within a universally defined and largely comprehensive package.

Against this backdrop, the MoHFS recognized the need to strengthen the BHS framework with a more rigorous,

explicit and evidence informed approach to internal prioritization, based on transparent criteria such as disease burden, cost effectiveness, equity impact and financial feasibility. This recognition led to the initiation of a comprehensive, evidence informed priority setting exercise to create a strong evidence base for the review, revision and updating of Nepal's BHSP. The exercise aims to improve coherence between policy commitments, planning, financing and service delivery, and to ensure that publicly financed basic health services maximize population health gains, promote equity and support the progressive realization of UHC by 2030.

1.5 Objectives

The overall objective of the priority setting exercise is to support the review, revision and updating of Nepal's BHSP by systematically identifying and prioritizing BHS interventions that deliver the greatest health gains, promote equity and remain feasible within the country's fiscal and health system capacity.

Specifically, the objectives of the priority setting exercise are to:

i) Design and apply explicit priority setting criteria to systematically assess and rank health interventions, ensuring that decisions are guided by evidence on disease burden, cost effectiveness, equity impact, policy relevance and feasibility;

ii) Develop a realistic, evidence informed and value informed list of priority BHS interventions that supports efficient resource allocation while advancing equitable access and improved population health outcomes across Nepal; and

iii) Generate actionable recommendations to inform policy, planning and financing decisions, including guidance on how prioritized interventions can be integrated into the BHSP and aligned with implementation, monitoring and evaluation mechanisms within the health system.

Through these objectives, the exercise seeks to move from an implicit and expansive service listing towards a more focused and strategic approach to internal prioritization, strengthening coherence between entitlements, resource allocation and implementation, and supporting the progressive realization of UHC in Nepal. The rankings and priority groups produced by the exercise inform three related but distinct decisions: which interventions the package includes, the order in which they are financed and scaled up, and how resources are allocated within it.

The exercise was undertaken under the mandate of the MoHFS as part of its initiative to review and revise the BHSP, and it was anchored in the Ministry's own governance structures. A Steering Committee, chaired by the Additional Secretary of the MoHFS with the Secretary as advisor, provided policy direction and strategic oversight and is responsible for endorsing the results, while a Technical Working Committee (TWC), chaired by the Chief of the Public Health Coordination and Information Technology Division, guided the technical design and analysis (Annex 2). The BCEPS FairChoices team, together with NHEA as its in country partner, coordinated the analytical work and the consultations on behalf of the MoHFS, working with the divisions and centres of the Department of Health Services, provincial health authorities and other stakeholders (Chapter 3).

2

Health System Context

2 Health System Context

2.1 Population health status

Nepal has achieved substantial improvements in population health over the past three decades, reflecting sustained investment in primary health care, public health programmes and social development. Between 1996 and 2022, the maternal mortality ratio declined from 539 to 151 per 100,000 live births,[17] and the infant and neonatal mortality rates fell from 79 to 28 and from 39 to 21 per 1,000 live births, respectively.[18] These gains reflect the effectiveness of long standing interventions in maternal, newborn and child health, immunization and infectious disease control.

At the same time, the burden of disease has shifted markedly towards NCDs, which accounted for approximately 70.2% of all deaths in 2023,[19] while communicable diseases and reproductive, maternal, newborn, child and adolescent health and nutrition (RMNCAH-N) conditions continue to contribute substantially to morbidity and mortality. This dual burden requires the health system to sustain hard won gains in traditional public health areas while expanding capacity for the long term prevention and management of chronic conditions. Persistent inequities in access to and quality of services across geographical regions, socioeconomic groups and population subgroups are reflected in Nepal's UHC service coverage index, which remained relatively low at 58 in 2023.[20]

The estimates of the burden of disease presented in the rest of this section are based on the Global Burden of Disease (GBD) Study 2023 by the Institute for Health Metrics and Evaluation (IHME).[19] The study assessed the burden of 375 diseases and injuries[21] by estimating key metrics such as years lived with disability (YLDs), years of life lost (YLLs), disability adjusted life years (DALYs) and healthy life expectancy (HALE).

2.1.1 Life expectancy

Between 1990 and 2023, life expectancy at birth showed a steady and sustained improvement, from 58.1 years in 1990 to 73.5 years in 2023 (Figure 2). This consistent rise reflects continuous progress in health outcomes, driven by advances in health care, improved maternal and child health, a declining burden of infectious diseases and broader socioeconomic development.

2.1.2 Disease burden by cause

In 2023, cardiovascular disease accounted for the highest disease burden, with a rate of 4,381 DALYs per 100,000 population, followed by maternal and neonatal disorders (2,991 DALYs per 100,000 population), chronic respiratory diseases (2,289), respiratory infections and tuberculosis (2,248) and musculoskeletal disorders (2,092). In 1990, all five leading causes of disease burden were communicable, maternal, neonatal and nutritional (CMNN) diseases; by 2023, the leading causes had shifted towards NCDs (Figure 3).

2.1.3 Deaths

In 2023, deaths were predominantly driven by NCDs, particularly cardiovascular diseases (27.4%), followed by chronic respiratory diseases (16.0%), neoplasms (9.5%) and respiratory infections including tuberculosis (8.4%). Maternal and neonatal disorders, digestive diseases, diabetes and kidney diseases, unintentional injuries and self harm also contributed meaningful shares.

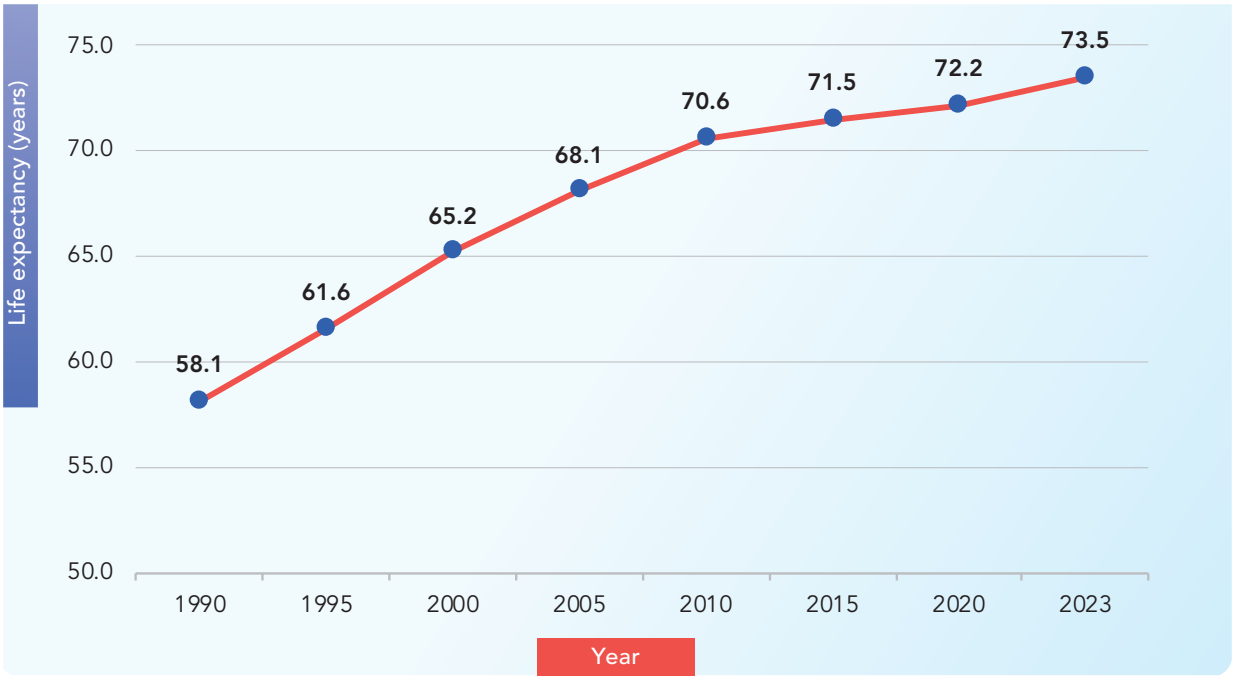


Figure 2: Life expectancy in Nepal, 1990–2023

Source: Global Burden of Disease Study 2023, Institute for Health Metrics and Evaluation.[19]

Mortality from conditions such as HIV and sexually transmitted infections, neglected tropical diseases, nutritional deficiencies and musculoskeletal disorders remained relatively low (Figure 4).

2.1.4 Disability adjusted life years

The largest contributors to DALYs were cardiovascular diseases (approximately 14%), maternal and neonatal disorders (approximately 10%), chronic respiratory diseases (7.4%), respiratory infections including tuberculosis (7.2%), musculoskeletal disorders (6.7%), unintentional injuries (6.3%) and mental disorders (5.9%). Nutritional deficiencies, neurological disorders, digestive diseases, diabetes and kidney diseases, and enteric infections also contributed substantial losses.

2.1.5 Burden of disease at subnational level

Subnational estimates of the burden of disease were derived by redistributing the national GBD 2023 estimates across the seven provinces according to the age and sex structure of each province's population, based on official population projections.[19] The approach keeps the provincial estimates consistent with the national totals; rates per 100,000 population for deaths and DALYs were converted into absolute numbers using provincial population sizes. A consolidated summary for all provinces is given in Annex 1 (Table 34).

NCDs account for the largest share of the burden in every province, from 54.6% of DALYs in Madhesh to 66.9% in Koshi, and cardiovascular disease is the leading cause of DALYs in all seven provinces (13.1% to 16.0%). Maternal and neonatal disorders rank second in six provinces; in Madhesh, unintentional injuries rank second. Communicable, maternal, neonatal and nutritional conditions together with injuries account for larger shares of DALYs in Madhesh (45.4%), Karnali (44.6%), Lumbini (42.1%) and Sudurpashchim (41.7%), reflecting their younger populations, while

CMNN diseases NCDs Injuries Same or higher rank Lower rank

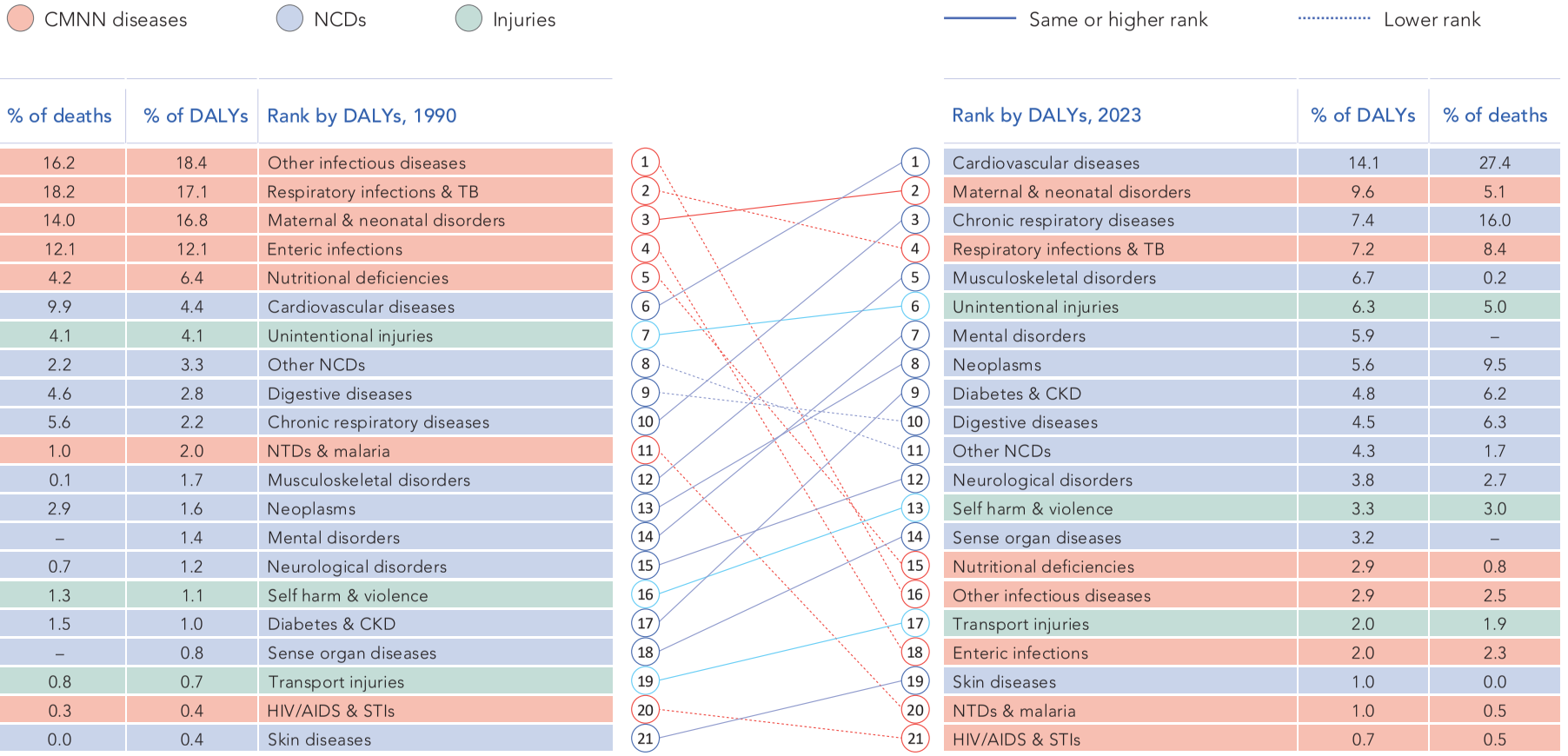
Prevalence	Mortality rate	DALYs	Rank by DALYs, 1990		Rank by DALYs, 2023	DALYs	Mortality rate	Prevalence
3,649.0	184.1	15,616.1	Other infectious diseases	1	1 Cardiovascular diseases	4,381.0	158.5	4,952.2
40,655.0	206.8	14,511.8	Respiratory infections & TB	2	2 Maternal & neonatal disorders	2,991.1	29.4	1,880.0
3,078.9	158.3	14,259.9	Maternal & neonatal disorders	3	3 Chronic respiratory diseases	2,289.2	92.5	4,444.3
2,473.3	137.7	10,254.6	Enteric infections	4	4 Respiratory infections & TB	2,247.8	48.5	20,452.2
63,454.7	47.9	5,457.6	Nutritional deficiencies	5	5 Musculoskeletal disorders	2,091.9	1.4	20,239.3
3,095.5	112.5	3,692.7	Cardiovascular diseases	6	6 Unintentional injuries	1,957.9	29.1	13,020.3
9,513.8	47.0	3,443.8	Unintentional injuries	7	7 Mental disorders	1,839.0	–	12,850.5
62,484.1	25.4	2,768.9	Other NCDs	8	8 Neoplasms	1,750.7	55.8	379.6
16,311.0	52.3	2,370.8	Digestive diseases	9	9 Diabetes & CKD	1,495.9	36.2	12,790.7
3,241.8	63.6	1,824.4	Chronic respiratory diseases	10	10 Digestive diseases	1,390.8	36.5	23,304.2
77,242.4	11.0	1,686.8	NTDs & malaria	11	11 Other NCDs	1,354.2	9.9	62,964.5
14,057.1	0.8	1,476.4	Musculoskeletal disorders	12	12 Neurological disorders	1,192.5	15.8	37,699.0
–	33.0	1,312.0	Neoplasms	13	13 Self harm & violence	1,130.5	17.1	5,413.8
9,110.3	–	1,215.5	Mental disorders	14	14 Sense organ diseases	993.2	–	27,695.1
32,497.8	8.4	1,006.6	Neurological disorders	15	15 Nutritional deficiencies	912.1	4.5	28,830.0
4,191.8	14.9	970.6	Self harm & violence	16	16 Other infectious diseases	891.0	14.2	2,182.0
8,035.4	17.0	946.1	Diabetes & CKD	17	17 Transport injuries	621.1	11.0	610.8
18,260.5	–	695.2	Sense organ diseases	18	18 Enteric infections	620.2	13.1	487.0
648.4	8.6	587.5	Transport injuries	19	19 Skin diseases	311.3	0.02	11,123.1
6,503.3	3.9	342.8	HIV/AIDS & STIs	20	20 NTDs & malaria	311.0	2.3	20,529.5
11,507.7	0.0	340.8	Skin diseases	21	21 HIV/AIDS & STIs	209.9	3.1	8,265.9

Figure 3: Burden of disease in Nepal, 1990 and 2023

Note: Prevalence, mortality and DALYs are rates per 100,000 population. CMNN: communicable, maternal, neonatal and nutritional diseases; CKD: chronic kidney disease; NTDs: neglected tropical diseases; STIs: sexually transmitted infections.

Source: Global Burden of Disease Study 2023, Institute for Health Metrics and Evaluation.[19]

CMNN diseases | NCDs | Injuries | Same or higher rank | Lower rank



% of deaths	% of DALYs	Rank by DALYs, 1990		Rank by DALYs, 2023	% of DALYs	% of deaths
16.2	18.4	Other infectious diseases	1	Cardiovascular diseases	14.1	27.4
18.2	17.1	Respiratory infections & TB	2	Maternal & neonatal disorders	9.6	5.1
14.0	16.8	Maternal & neonatal disorders	3	Chronic respiratory diseases	7.4	16.0
12.1	12.1	Enteric infections	4	Respiratory infections & TB	7.2	8.4
4.2	6.4	Nutritional deficiencies	5	Musculoskeletal disorders	6.7	0.2
9.9	4.4	Cardiovascular diseases	6	Unintentional injuries	6.3	5.0
4.1	4.1	Unintentional injuries	7	Mental disorders	5.9	–
2.2	3.3	Other NCDs	8	Neoplasms	5.6	9.5
4.6	2.8	Digestive diseases	9	Diabetes & CKD	4.8	6.2
5.6	2.2	Chronic respiratory diseases	10	Digestive diseases	4.5	6.3
1.0	2.0	NTDs & malaria	11	Other NCDs	4.3	1.7
0.1	1.7	Musculoskeletal disorders	12	Neurological disorders	3.8	2.7
2.9	1.6	Neoplasms	13	Self harm & violence	3.3	3.0
–	1.4	Mental disorders	14	Sense organ diseases	3.2	–
0.7	1.2	Neurological disorders	15	Nutritional deficiencies	2.9	0.8
1.3	1.1	Self harm & violence	16	Other infectious diseases	2.9	2.5
1.5	1.0	Diabetes & CKD	17	Transport injuries	2.0	1.9
–	0.8	Sense organ diseases	18	Enteric infections	2.0	2.3
0.8	0.7	Transport injuries	19	Skin diseases	1.0	0.0
0.3	0.4	HIV/AIDS & STIs	20	NTDs & malaria	1.0	0.5
0.0	0.4	Skin diseases	21	HIV/AIDS & STIs	0.7	0.5

Figure 4: Proportion of deaths and DALYs due to different causes, 1990 and 2023

Source: Global Burden of Disease Study 2023, Institute for Health Metrics and Evaluation.[19]

Gandaki, Koshi and Bagmati, with older populations, have the highest crude DALY rates (33,145 to 36,648 per 100,000 population, against 22,533 in Madhesh and 22,686 in Karnali).

These estimates describe the burden in a typical year and do not reflect the episodic burden of large natural disasters, which are not usually counted as burden of disease events. The flash flood along the Bhotekoshi and Trishuli corridor in August 2026 had caused 1,453 confirmed deaths by 25 September, with 5,285 people still missing, so that this single event already outranked seven of the 21 causes of death tracked for Nepal; it also destroyed or damaged health facilities and cut off referral routes, as the 2015 and 2023 earthquakes and the 2017 and 2024 floods had done before.[22] For the revised BHSP, the lesson is that continuity of basic health services, including essential emergency and critical care, should be built in as a standing requirement financed through recurrent budget lines and regular fiscal transfers to provincial and local governments, rather than added as an emergency response after each disaster, in line with the "Always On" approach discussed in Section 6.4.

2.2 Health care delivery system

Nepal's health care delivery system is built on a comprehensive and inclusive approach that aims to ensure accessibility, quality and responsiveness to emerging health needs. Guided by a strong commitment to UHC, the system continues to evolve towards greater efficiency, equity and resilience, with the Constitution of Nepal (2015) providing the overarching legal foundation by recognizing health as a fundamental right (Section 1.4).

The current structure of Nepal's health system is the result of a long process of historical evolution shaped by political, institutional and policy reforms.[23,24] Modern health care in Nepal began with the establishment of Bir Hospital in 1889, marking a transition from a system predominantly based on traditional Ayurvedic practices to one incorporating modern medical services. The establishment of the Department of Health Services in 1933 further formalized health service delivery, although substantial expansion occurred only after the political transformation of 1951. Following the end of the Rana regime, Nepal initiated planned health development, with a strong emphasis on primary health care, expansion of rural health posts, and collaboration with national and international partners. These efforts contributed significantly to improvements in maternal and child health and communicable disease control.

The 1990s marked another important phase of reform following the restoration of multiparty democracy. The National Health Policy (1991) prioritized the expansion of primary health care services, the establishment of health facilities across all village development committees, and the mobilization of Female Community Health Volunteers (FCHVs). These interventions contributed substantially to improving service coverage and reducing maternal and child mortality. The Second Long Term Health Plan (1997–2017) further strengthened district health systems and expanded the delivery of essential health care services. The adoption of a sector wide approach (SWAp) in 2004 improved coordination among development partners, enhanced government leadership and supported the introduction of free essential health services, particularly for underserved populations.

A major structural shift occurred with the promulgation of the Constitution in 2015, which introduced a federal system of governance intended to enhance local autonomy, improve responsiveness to community needs, and strengthen decentralized planning and financing of health services. Federalization has, however, also introduced new challenges, including coordination across levels of government, variations in institutional capacity and equitable resource allocation, which are discussed in Section 2.2.2.

2.2.1 Structure and functioning of the health care delivery system

Nepal's health care delivery system underwent a substantive transformation following the country's transition to federalism in 2015.[25] The Constitution reorganized the nation into three tiers of government (federal, provincial and local), each with distinct yet interconnected responsibilities for health system governance and service delivery. This restructuring aimed to strengthen decentralization and improve equity in access. Although these levels operate independently, their effectiveness depends on continuous coordination of policy, resources and information flows across the system.

Federal level

At the federal level, the MoHFS performs the overarching stewardship role for the national health system. It is responsible for formulating health policies, establishing standards and regulatory frameworks, managing national level health programmes and coordinating intergovernmental health responses. These functions are executed through five divisions within the Ministry and three major departments: the Department of Health Services (DoHS), the Department of Ayurveda and Alternative Medicine (DoAAM) and the Department of Drug Administration (DDA).[26] Among these, the DoHS is the principal operational arm, responsible for implementing public health programmes, managing national logistics, coordinating disease surveillance systems, and providing technical and supervisory support to provincial and local governments. Specialized centres under the DoHS, namely the National Health Education, Information and Communication Centre (NHEICC), the National Tuberculosis Control Centre, the National Centre for AIDS and STD Control, the National Health Training Centre and the National Public Health Laboratory, provide programmatic and laboratory support that extends throughout the country. Federal hospitals and academies offer tertiary and super specialized services and form the apex of the national referral network.

Provincial level

The provincial tier serves as the intermediate governance level within Nepal's decentralized system. Each of the seven provinces has a Ministry of Health (or equivalent) that adapts federal policies to the provincial context and oversees the implementation of health programmes across district and local levels. Provincial ministries manage hospitals with fewer than 200 beds and supervise public health laboratories, logistics management units and provincial health offices at the district level. They play an essential role in quality assurance, supportive supervision and coordination of health services among municipalities. Provincial health directorates act as conduits between federal guidelines and local implementation, ensuring that national programmes such as immunization, disease surveillance, reproductive

health and nutrition services are executed effectively. Provinces also rely on federal institutions for technical guidance, policy, national supply chain systems, capacity building and specialized expertise.

Local level

At the local level, municipal governments are constitutionally mandated to deliver BHS, making them the frontline interface with communities. Local governments manage a network of health facilities, including basic hospitals (which include the former PHCCs), basic health service centres (which include the former health posts), urban health centres, urban health promotion centres and community health units, each responsible for providing public health and primary clinical care, maternal and child health services, essential medicines and outreach services. They oversee human resources for

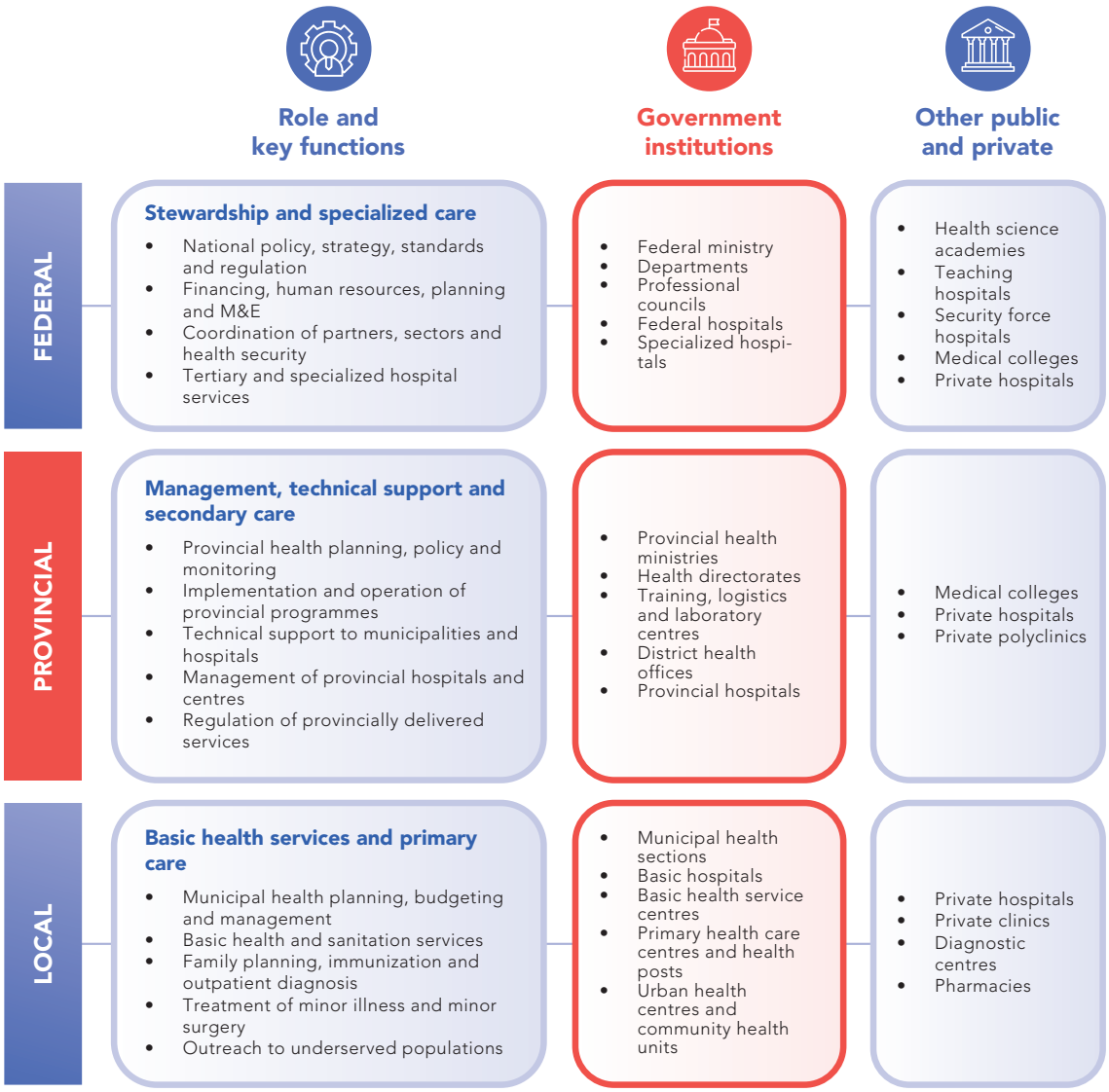


Figure 5: Structure and functions of the federal health system in Nepal

Note: FCHVs: Female Community Health Volunteers; M&E: monitoring and evaluation.

Source: Based on the Constitution of Nepal (2015),[13] the Local Government Operation Act (2017),[27] the Public Health Service Act (2018)[14] and the Public Health Service Regulation (2020).[15]

basic health care, conduct local level planning and budgeting, manage procurement, and implement community based programmes through structures such as FCHVs. Local governments also generate service delivery data that feed into the national DHIS2 based Health Management Information System (HMIS), which supports evidence based planning and monitoring at all levels of government.

The main roles and functions of the three tiers, and the government and other institutions at each tier, are summarized in Figure 5.

The integration of these three tiers is supported by several system wide mechanisms. A tiered referral structure links community based services to progressively higher levels of care, culminating in provincial and federal hospitals for advanced treatment. Logistics and supply chain management is coordinated across levels: federal entities are responsible for national procurement and standards, provincial authorities manage subnational distribution, and local level facilities ensure last mile delivery and stock management. Human resources for health are similarly governed through shared responsibility: federal bodies manage policy and specialist deployment, provincial governments oversee staffing in provincial hospitals, and local governments manage frontline personnel. Disease control programmes, including those for tuberculosis, HIV, malaria, maternal and newborn health and immunization, are designed at the federal level, supervised by the provinces and implemented locally, an arrangement that depends on coordination between the three tiers.

In addition, the private and nongovernmental sectors constitute an important component of Nepal's health care system, especially in urban and semiurban settings. Private hospitals, clinics, diagnostic centres, pharmacies and medical colleges complement public services by delivering curative, diagnostic and emergency care. Public–private partnerships (PPPs) are increasingly encouraged to expand service coverage and resource sharing in underserved areas. Nongovernmental organizations (NGOs), international nongovernmental organizations (INGOs) and health development partners (HDPs) continue to support health promotion, capacity building and disease control initiatives, aligning their interventions with federal, provincial and local priorities.

In effect, the federal health system functions through decentralized governance supported by interdependent operational linkages. This architecture reflects a deliberate effort to align national health priorities with local needs while ensuring that all citizens can access quality health services without financial hardship, as envisioned in Nepal's constitutional commitment to health as a fundamental right.

2.2.2 Structural issues and potential in the federal system

Following federalization, Nepal has made progress in decentralizing authority, enhancing local accountability and tailoring health services to community needs. Expansion of health infrastructure, improved mobilization of human resources and the establishment of basic hospitals across municipalities have contributed to strengthening service access.

However, the transition has also exposed several systemic challenges. Functional responsibilities across the three tiers are only partly clarified, and resources remain concentrated

at the federal level: over FY 2080/81 to 2083/84, the federal level retained 56.9% of the health budget, while 36.5% was transferred to the 753 local levels and 6.7% to the seven provinces, mostly as conditional grants.[28] Facility readiness at the level that delivers BHS remains limited. In the 2021 Nepal Health Facility Survey, fewer than 1% of public facilities offered the full set of 41 basic health services assessed, only 11% had all six basic amenities (91% of local level facilities lacked at least one), 41% of local level facilities had all seven items of basic equipment, and only 1% of public facilities had all 20 tracer medicines available.[29] Staffing gaps are equally marked: 71% of sanctioned positions were filled in local level facilities and 58% in provincial facilities, with only 40% of medical officer positions filled at local level and 36% of doctor positions at provincial level.[29] Within local budgets, health workforce salaries absorb about 63% of health allocations and medicine procurement about 3%, which leaves limited room for programmes and supplies (Section 5.6).[28] Coordination gaps have led to overlaps and inconsistencies in programme implementation, and issues such as deprioritization of the health sector, unclear authority and resistance to decentralization continue to impede progress.

Health information systems have expanded but remain fragmented. Routine data are collected through separate systems for service statistics (the DHIS2 based HMIS), logistics (e-LMIS), the health workforce (NHWR), facilities and infrastructure (NHFR and HIIS), training (TMIS), finance (FMIS), planning (PLAMAHS) and Ayurveda services (AHMIS), with limited interoperability between them; patient level records are rare outside hospitals, where electronic records are used mainly for billing.[30] All 753 local governments report service statistics electronically to the national HMIS, but only about half of private facilities (53%) are represented in it, against 90% of public facilities, and 55% of health facilities have a computer with internet access.[30] Completeness and timeliness of reporting from public facilities are high, but consistency is weaker: in Lumbini Province, maternal, newborn and child health reports were 98% to 100% complete and 94% to 96% timely, yet data were consistent over time in only 4 of 12 districts.[31] These gaps limit the use of routine data for tracking the coverage of individual interventions, for local planning and for monitoring financial protection (Sections 6.3.5 and 7.3).

Despite these challenges, federalization presents significant opportunities for building a more equitable and community responsive health system. Strengthening governance, intergovernmental coordination, human resource capacity and accountability mechanisms is essential for advancing UHC. Priority opportunities include contextualizing the revised BHSP to provincial and local levels, developing local health policies, clarifying PPP frameworks, improving budgeting processes, expanding infrastructure, enhancing data systems for real time decision making, and establishing structured capacity development plans aligned with the new federal roles and responsibilities.

2.3 Health financing

Health financing is a core function of the health system that determines how resources are generated, pooled, allocated and used to deliver equitable and quality health services. It shapes not only the availability of financial resources but also how efficiently and equitably these resources are used to achieve key health system goals,

including UHC, financial protection and improved population health outcomes. In Nepal, health financing has evolved alongside political transformation, decentralization and rising demand for health care services.[32,33] While the country has made notable progress in expanding access to essential services, significant challenges remain in ensuring adequate, efficient and equitable financing.

2.3.1 Sources and trends in health financing

Nepal's health financing system operates through a mixed, multisource structure consisting of general taxation, social health insurance, external development assistance and out of pocket (OOP) payments. Among these, public financing through general taxation remains the primary formal source of funding. Resources are allocated from the Ministry of Finance (MoF) to the MoHFS and subsequently distributed across federal, provincial and local governments in line with national priorities. With the introduction of federalism, subnational governments have taken on an increasingly important role in financing and delivering health services, particularly BHS.

Figure 6 shows the composition of current health expenditure (CHE) in Nepal over 14 fiscal years. Overall, it reveals a persistent dominance of household OOP spending, a gradual but insufficient increase in government financing, a declining contribution from external development partners and a very limited role for health insurance.[34,35]

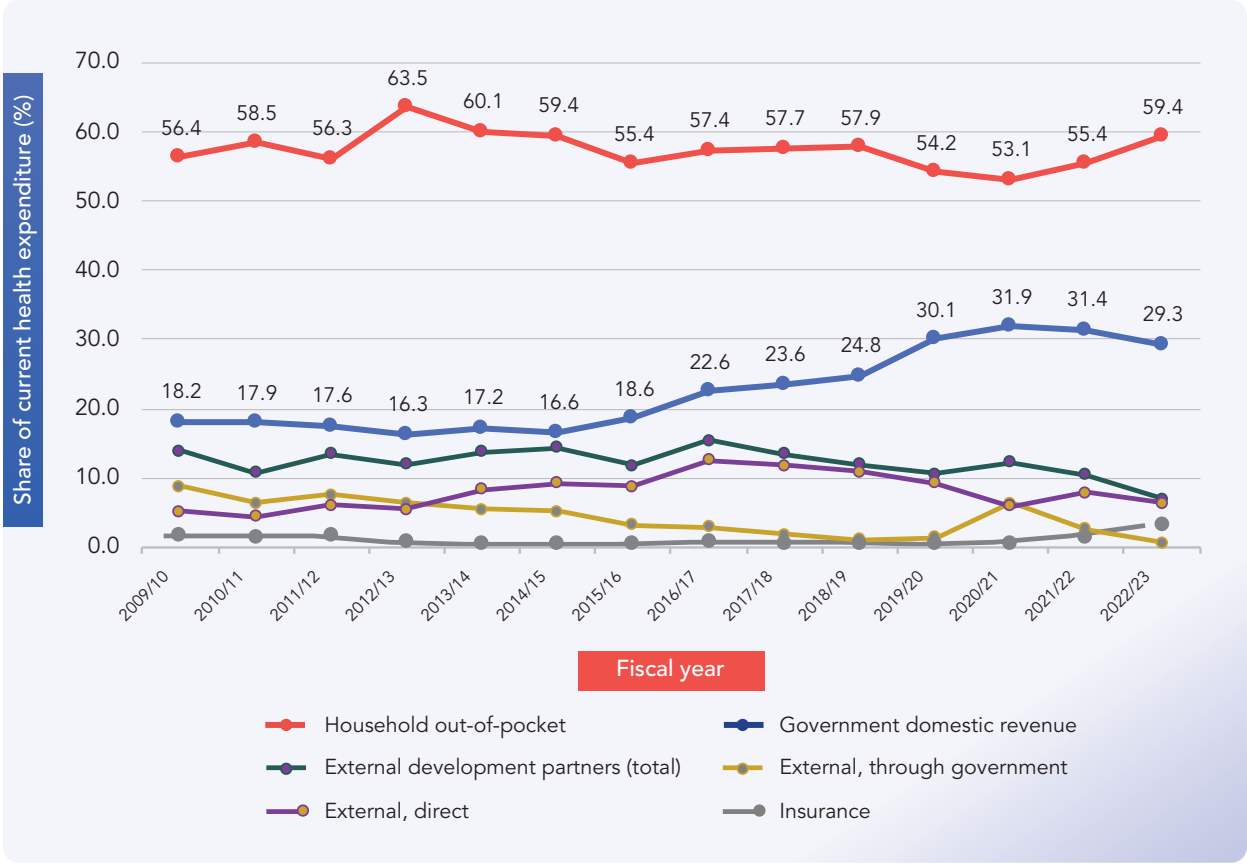


Figure 6: Distribution of current health expenditure by source

Source: Nepal National Health Accounts and WHO Global Health Expenditure Database.

Household OOP expenditure remains the largest component throughout the period. Despite various policy efforts aimed at improving financial protection and advancing UHC, there has been no sustained reduction in the household share, reflecting weak risk pooling mechanisms and limited protection against catastrophic health expenditure.

Government health financing shows a steady upward trend, increasing from about 18.2% of CHE in 2009/10 to around 29.3% in 2022/23. This is a positive shift in public investment, particularly following the transition to federal governance, although the level remains insufficient to reduce the financial burden on households significantly.

External development assistance shows an overall declining trend. Funding routed through government channels fluctuated at around 6–9% in the early years but declined after 2015 to very low levels in recent years, while direct external funding peaked at approximately 12–13% around 2016/17 before steadily declining to below 10% thereafter. Development partners such as WHO, UNICEF, Gavi, the Global Fund, UNFPA, GIZ and the World Bank continue to support key public health programmes, although their contribution has diminished over time. Foreign aid remains a critical source of health financing and technical support in Nepal, and the abrupt discontinuation of United States assistance poses significant risks to global health security, service delivery and equitable access to quality care. Within the MoHFS budget, the share financed by development partners fell from 18.3% in FY 2080/81 to 8.3% in FY 2083/84, and from 45.9% to 13.8% for health promotion and preventive services; the programmes most exposed, such as immunization, nutrition, HIV and tuberculosis, and the need for a costed transition plan are discussed in Section 5.4.1.

Health insurance accounts for a very small proportion of CHE, generally remaining below 4%, with only a slight increase in recent years. The National Health Insurance Program, launched in 2016, now covers roughly 33% of the population.[36] Despite its intention to reduce financial hardship, the scheme faces low enrolment, sustainability concerns, adverse selection, low benefit ceilings, quality concerns and limited provider participation.[37] Its limited financial contribution suggests that it has not yet become a significant mechanism for reducing OOP expenditure or improving financial protection.

Overall, Nepal's health financing system remains heavily dependent on household spending, with only gradual progress towards strengthening public financing and pooled funding mechanisms (Table 2).

Table 2: Key statistics on health expenditure in Nepal, 2005–2023

Indicator	2005	2010	2015	2019	2023
Health spending per capita, current health expenditure (US$)	14	30	46	54	84
Health spending per capita, current health expenditure (NPR)	1,000	2,200	4,700	6,100	11,100
Government domestic health spending as % of CHE (GGHE-D % CHE)	19.1%	18.1%	16.6%	24.8%	31.3%

Indicator	2005	2010	2015	2019	2023
Out of pocket spending as % of CHE (OOPS % CHE)	49.2%	56.2%	59.4%	57.9%	59.4%
Priority to health: GGHE-D as % of general government expenditure	6.3%	4.8%	5.1%	4.0%	7.7%
GDP per capita (US$)	358	679	851	1,206	1,363
GDP per capita (NPR)	25,600	49,700	87,200	135,800	180,100

Note: NPR values are converted from US dollars at the annual average official exchange rate reported by the World Bank (NPR 71.4, 73.2, 102.4, 112.6 and 132.1 per US dollar in 2005, 2010, 2015, 2019 and 2023) and rounded to the nearest 100.

Source: Global Health Expenditure Database, World Health Organization.[35]

Per capita health spending increased substantially, from US$14 (about NPR 1,000) in 2005 to US$84 (about NPR 11,100) in 2023, a nearly sixfold rise that broadly tracks the increase in GDP per capita (from US$358 to US$1,363). The rise in health spending has therefore broadly kept pace with economic growth, without a marked increase in the priority given to health. Despite the rise in per capita health expenditure, OOP payments have remained persistently high, so the additional resources have not been accompanied by a larger pooled share.

2.3.2 Health care financing mechanism

The fund flow within Nepal's health system is depicted in Figure 7, which highlights the interlinkages between the MoF, the MoHFS, the various social health protection schemes and health service providers, and shows how financial resources are mobilized, pooled and used to finance health services for the population.

The MoF generates public revenue and allocates it to the MoHFS through the national budget, including conditional grants to provinces and local governments for BHS. The MoHFS, operating through a line item budgeting system, distributes these funds to federal health institutions and provides additional grants to provincial and local governments to support the effective implementation of health services across all levels.

Several intermediaries pool and manage health financing between the population and service providers. The Health Insurance Board collects premiums from the insured and reimburses facilities after claim verification. Private insurers similarly collect premiums and reimburse treatment costs to the insured after service use. The Social Security Fund and the Employees Provident Fund pool payroll contributions from employees and employers, primarily for social protection and retirement, with some provisions available to support medical expenses.

Health funds are channelled to a wide range of public and private providers, from federal and provincial hospitals to health posts, private hospitals,

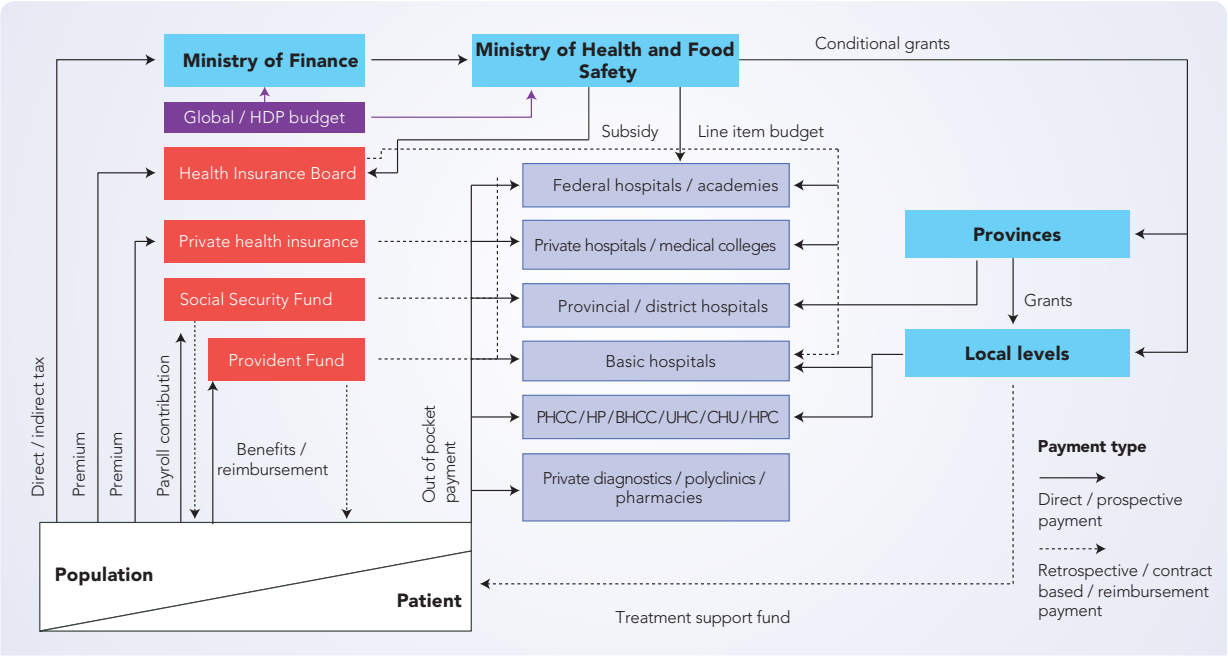


Figure 7: Health financing flow of Nepal

Source: Infographic designed by Ravi Kanta Mishra for this report

medical colleges and diagnostic centres, through government budgets, insurance reimbursements and patient payments. The population contributes through taxes, insurance premiums, payroll deductions to social protection schemes and OOP payments. For those unable to afford care, mechanisms such as the Deprived Citizen Treatment Fund offer targeted financial protection.

The health system operates through two primary financial flow mechanisms. Prospective (direct) payments involve advance budget allocations, such as MoHFS line item budgets to federal hospitals and conditional grants to provincial and local governments. Retrospective (reimbursement based) payments are made after services are provided, with facilities receiving funds based on verified claims; this is the model used by the Health Insurance Board and private insurers. Health services delivered through federal, provincial and local governments are primarily tax funded, supplemented by development partner contributions and health insurance, and further complemented at the facility level by OOP payments made by households at the point of care.

Nepal's health financing arrangements have evolved considerably, and the recently adopted NHFS (2023–2033)[12] outlines pathways to further improve resource mobilization, allocation and efficiency towards achieving UHC.

2.3.3 Financial risk and out of pocket expenditure

Nepal's health system faces persistent financial protection challenges, with OOP spending accounting for 59.4% of CHE, one of the highest levels in the region.[35] High reliance on OOP payments exposes households to catastrophic health costs, particularly in rural and marginalized communities. The slow progress of the national health insurance programme (Section 2.3.1), underfunded public facilities, weak supply chains and heavy dependence on private services further intensify financial risk.

Government initiatives, including free BHS, the Aama (safe motherhood) Programme, the Bipanna Nagarik Upachar Kosh (Deprived Citizen Treatment Fund) and the national health insurance scheme, have sought to strengthen financial protection, but hidden costs and sustainability issues persist. Additional schemes include disease specific support (childhood cancer, HIV/AIDS, tuberculosis, leprosy and burns), monthly cash transfers of NPR 5,000 to patients with cancer, kidney disease or spinal injury, and subsidies for marginalized groups. Despite these efforts, the system remains fragmented, with overlapping mandates, varying benefit packages and limited coordination across programmes, affecting efficiency, equity and progress towards UHC.

2.3.4 Current fiscal space for health

Fiscal space is the budgetary room that allows a government to provide resources for public purposes without affecting fiscal sustainability. Domestic government health spending in Nepal was about 1.9% of GDP in 2023,[35] well below the benchmark of 5% of GDP in public spending that is often cited as needed for progress towards UHC.[38] Limited domestic revenue, slow economic growth and competing national priorities continue to restrict public spending in the sector, while heavy reliance on external assistance persists for programmes such as immunization, HIV/AIDS, nutrition and reproductive health.

The priority given to health in public budgets has also varied over time. Domestic general government health expenditure, which includes spending by all three tiers of government, fell from 6.3% of general government expenditure in 2005 to 4.0% in 2019 before rising to 7.7% in 2023, the latest year available (Table 2).[35] The federal budget allocated to the MoHFS, including conditional grants to provinces and local levels, has remained below 5% of the national budget: 4.9% in FY 2080/81, 4.6% in FY 2081/82, 4.9% in FY 2082/83 and 4.5% (NPR 96.4 billion of NPR 2,124.3 billion) in FY 2083/84 (Table 3).[28,39] The two measures differ: the first covers health spending by all three tiers of government from domestic sources as a share of general government expenditure, whereas the second covers only the MoHFS allocation, including conditional grants, as a share of the federal budget, which is why the share in Table 2 is higher than that in Table 3.

Table 3: Federal health budget as a share of the national budget, FY 2080/81 to 2083/84

Fiscal year	National budget (NPR billion)	MoHFS allocation, including conditional grants (NPR billion)	Share (%)
2080/81 (2023/24)	1,751.3	86.1	4.9
2081/82 (2024/25)	1,860.0	85.9	4.6
2082/83 (2025/26)	1,964.1	95.8	4.9
2083/84 (2026/27)	2,124.3	96.4	4.5

Note: Approved allocations, not expenditure. The MoHFS allocation excludes health spending by provinces and local levels from their own revenue and equalization grants and therefore understates total public allocation to health.

Source: Budget speeches;[39] approved annual work plan and budget of the MoHFS.

Actual spending shows a similar pattern over a longer period. The share of federal expenditure allocated to health has been inconsistent over the past decade, declining from above 5.5% in the early years to around 3.2% before COVID-19, rising sharply to 6.4% during the pandemic, and falling again to around 4.4% in recent years (Figure 8). The share therefore rose markedly only during the pandemic and fell back afterwards. The current allocation remains significantly below the global benchmarks required for UHC, signalling the need for predictable and sustained investment in health system strengthening.

Options for expanding fiscal space and financing the BHSP are discussed in Chapter 5.

2.3.5 Public financial management and resource allocation

Budget allocations for health in Nepal often reflect political influence and historical patterns rather than technical assessments of need, and subnational governments continue to face limited capacity for evidence based planning. This mismatch is evident in practice: essential medicines frequently experience stockouts despite being mandated under BHS, and the expanding burden of NCDs remains underfinanced relative to its share of the disease burden. Public health emergencies such as dengue or cholera outbreaks often trigger unplanned budget reallocation, disrupting routine services and further destabilizing planned expenditure.

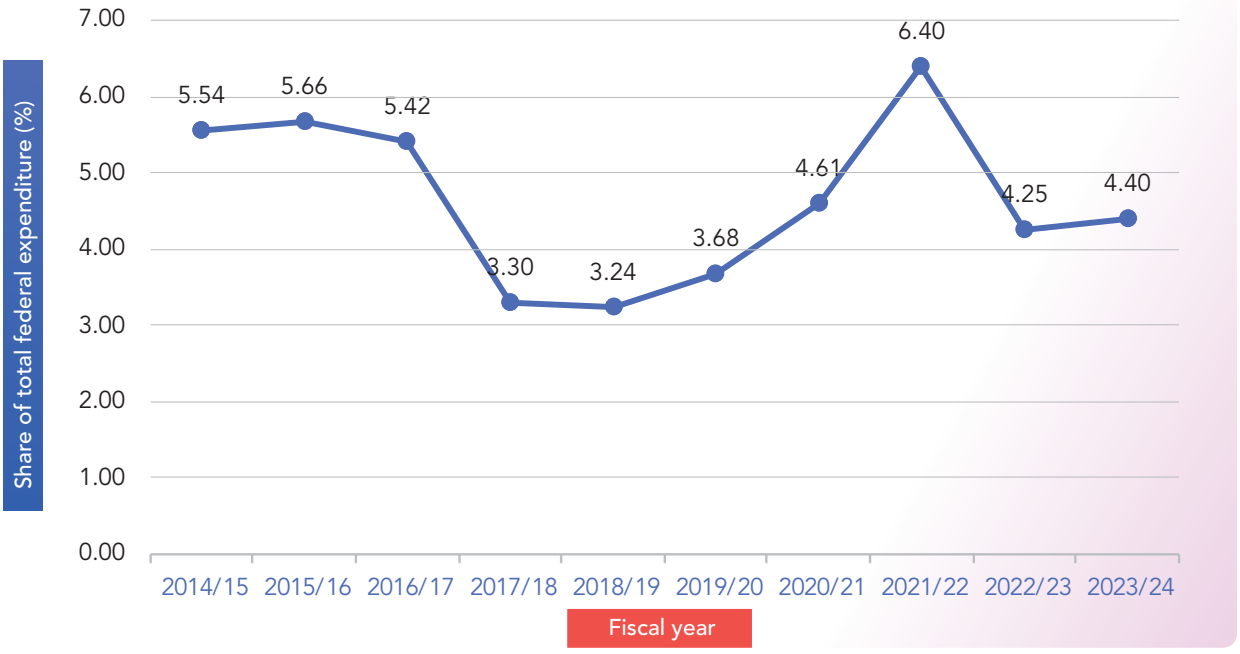


Figure 8: Health expenditure as a proportion of total expenditure at federal level

Source: Financial Comptroller General Office.[40]

Much of this disconnect is mediated by public financial management (PFM) systems, which govern budgeting, fund release, procurement, accounting and reporting. Financial performance, that is, whether budgets are fully and appropriately spent, whether services are delivered in a timely and equitable manner, and whether spending translates into improved health outcomes, is largely determined by how well health financing is managed through these PFM systems. Strong PFM ensures that allocated resources translate into actual service delivery through timely budget execution, efficient procurement and transparent financial management; weak PFM leads to delays, underspending, fragmentation and inefficiency, even when adequate financing is available.

As shown in Figure 9, Nepal's federalism has not yet produced a balanced fiscal structure. The federal government continues to dominate national expenditure, accounting for 59–69% of total spending over the last five years. Local governments maintain a relatively stronger fiscal presence than provincial governments, which consistently show the lowest spending share. Although subnational expenditure increased during COVID-19, this shift was temporary, and the system has since moved back towards recentralization. These patterns indicate the need for clearer expenditure assignments, stronger provincial capacity and a more predictable intergovernmental fiscal transfer system.

Conditional grants from the federal government to local governments have increased as a share of total transfers, while equalization grants have declined (Figure 10). These trends affect resource allocation not only for the health sector but also for other sectors.

Within the health sector, the distribution of the MoHFS budget by level of implementation shows the

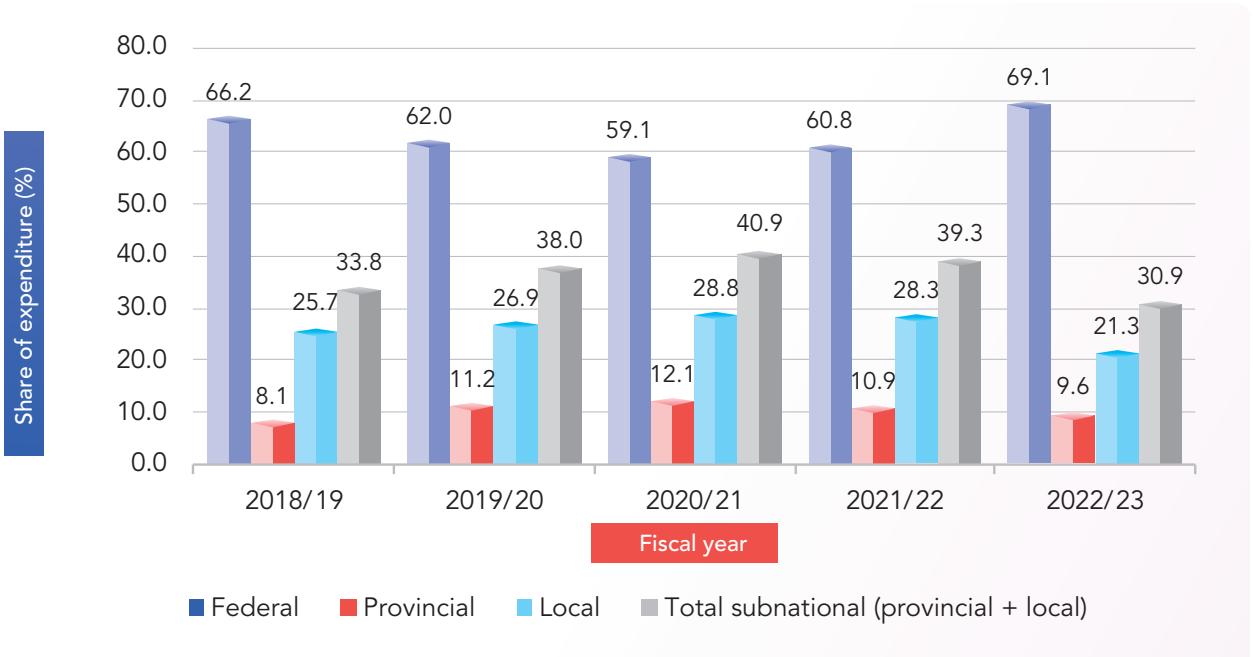


Figure 9: Expenditure share among the three tiers of government

Note: Total subnational is the sum of the provincial and local shares.

Source: Financial Comptroller General Office.[40]

same concentration: over FY 2080/81 to 2083/84, the federal level retained 56.9% of the budget, local levels received 36.5% and provinces 6.7%, mostly as conditional grants (Table 4).[28]

Table 4: Health budget by level of implementation, FY 2080/81 to 2083/84 (NPR million)

Level	2080/81	2081/82	2082/83	2083/84	Average	Share (%)
Federal (ministry, departments, hospitals, academies and programmes)	49,805	46,146	55,392	55,923	51,817	56.9
Province (conditional grants to 7 provinces)	6,127	6,350	6,054	5,625	6,039	6.7
Local (conditional grants to 753 local levels)	30,177	33,436	34,329	34,830	33,193	36.5
Total health budget	86,109	85,933	95,775	96,377	91,049	100

Source: Approved annual work plan and budget of the MoHFS, FY 2080/81 to 2083/84.

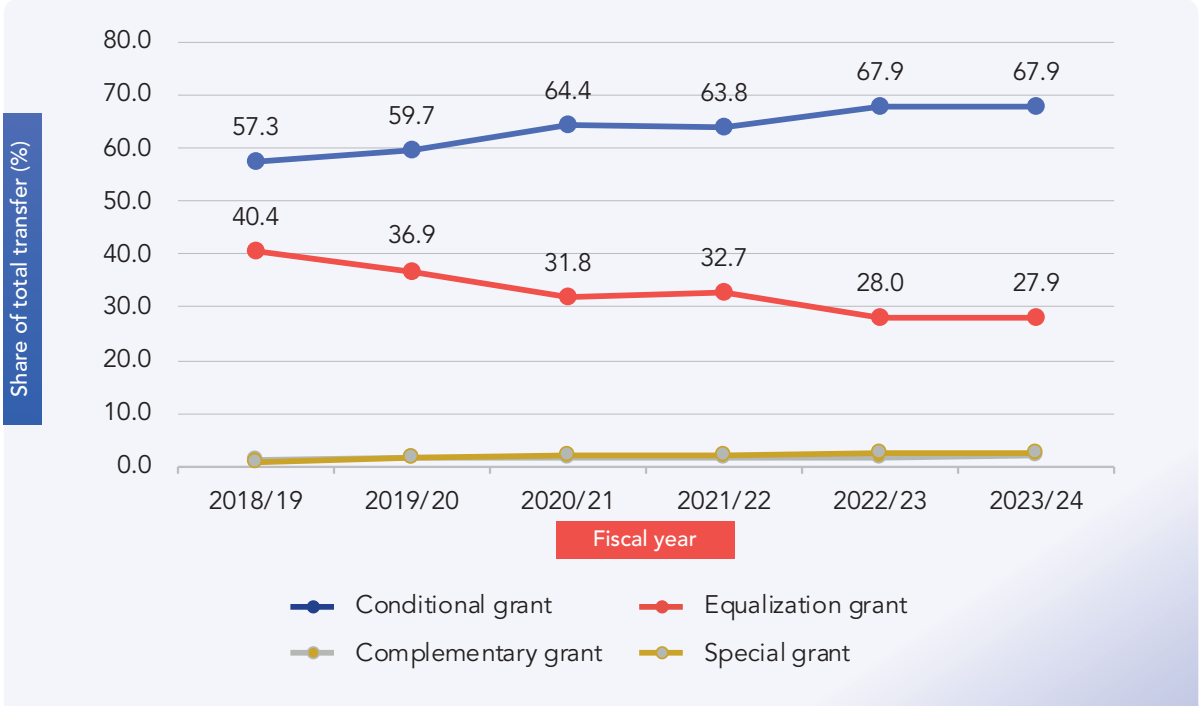


Figure 10: Transfers from the federal government to local governments

Source: Financial Comptroller General Office.[40]

Despite the identification and prioritization of essential interventions, the ability of Nepal's health system to translate these priorities into effective service delivery remains constrained by uncertainty in budget allocation. Allocations fluctuate from year to year, particularly at the local level, where between 18.5% and 26.7% of local levels saw their BHS allocation change by more than 20% from one year to the next (Section 5.6).[28] This reflects both the absence of a minimum guaranteed allocation for BHS functions and broader weaknesses in planning and fiscal forecasting, and it affects the distribution of funds across intervention categories, so that even

interventions deemed high priority do not reliably receive the resources required for consistent implementation.

Budget credibility is fundamental in this regard, as unrealistic plans, frequent revisions and delays in fund release disrupt service delivery. In Nepal, incremental and input based budgeting, together with weak financial systems, often results in inefficient resource use and limited impact on health outcomes. PFM weaknesses similarly constrain the success and sustainability of financing reforms such as health insurance, which are often limited by administrative and financial system capacity rather than by policy design. Nepal has made progress through its NHFS (2023–2033), but persistent challenges in efficiency, coordination, transparency and alignment of resources continue to limit the effectiveness of increased health spending. The implications of these constraints for financing the prioritized package are discussed in Chapter 5 (Sections 5.4.2 and 5.6).

3
Methods and Analytical Framework

3 Methods and Analytical Framework

Drawing on international experience with explicit priority setting and reflecting on Nepal's own policy and implementation history, the MoHFS initiated a formal, systematic priority setting process to support the progressive realization of UHC. Recognizing that resource constraints necessitate clear choices within the BHSP, this approach seeks to strengthen internal prioritization by identifying health interventions that deliver the greatest population health gains while advancing equity and financial protection. As a strategic pathway towards UHC, the process emphasizes prioritizing high impact interventions for near universal coverage, particularly for underserved and vulnerable populations, while remaining responsive to health system capacity and fiscal realities. Consistent with Nepal's long term development trajectory, the approach also acknowledges that the scope of publicly financed services can be expanded progressively as economic capacity grows.

To lead this priority setting initiative, the MoHFS established a dedicated governance structure comprising a Steering Committee and a Technical Working Committee (TWC) (composition in Annex 2). The Steering Committee provided overall policy direction and strategic oversight, while the TWC was responsible for technical design, analysis and implementation support. Regular meetings and iterative feedback between the two bodies enabled ongoing refinement of methods and contextualization of findings. BCEPS at the University of Bergen (UiB), together with its in country partner NHEA, worked closely with these bodies to provide technical support for the design and implementation of the priority setting process, under the leadership and oversight of the MoHFS and with strategic guidance from the Steering Committee. A roadmap for the priority setting exercise was developed and approved by the TWC.

3.1 Principles of priority setting

The priority setting exercise in Nepal was guided by the eight principles recommended in the WHO Principles of health benefit packages (2021).[10] These principles draw on the experience of countries that have undertaken explicit priority setting. They emphasize that the design of an essential benefit package should be democratic and inclusive, open and transparent, and well supported by evidence. They also stress that the package should be realistic within the current fiscal space and health system constraints and therefore linked to financing mechanisms and service delivery platforms (Figure 11). In addition, three principles guided each step of the process: engagement of relevant stakeholders, transparency about decisions and their rationale, and structured deliberation.[41]

3.2 Framework for priority setting

The priority setting process was organized following the BCEPS FairChoices framework, a ten step method for fair priority setting processes, developed and applied in the revision of the Zanzibar Essential Health Care Package[41] and adapted to Nepal's context. The ten steps are grouped into five phases: planning (development of a roadmap and establishment of a management structure); criteria and interventions (selection of prioritization criteria and identification of candidate interventions); financing (assessment of fiscal space and formulation of financing strategies); analysis and priority setting (evidence generation and analytics, and setting priorities); and implementation and monitoring

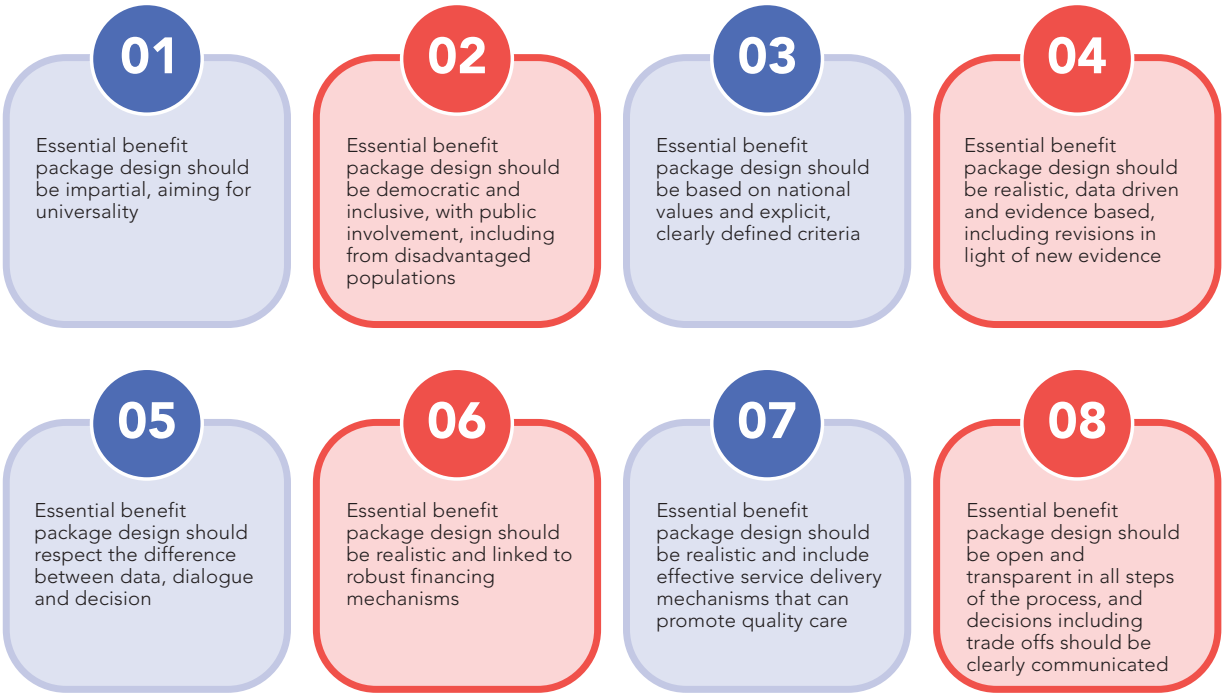


Figure 11: Principles of health benefit packages

Source: Adapted from Principles of health benefit packages, World Health Organization.[10]

(implementation arrangements and monitoring and evaluation). Table 5 summarizes how each step was applied in Nepal and where it is described in this report. The process was designed as a dynamic system with continuous feedback loops and periodic updates, so that it remains responsive to evolving health needs, policy shifts and emerging evidence.

Table 5: Application of the ten step method for priority setting in Nepal

Phase	Step	Application in Nepal	Section
Planning	1. Development of a roadmap	A roadmap for the priority setting exercise was developed and approved by the TWC	Chapter 3 (introduction)
	2. Establishment of management structure	Steering Committee and TWC established by the MoHFS, supported by programme specific thematic working groups; technical support from BCEPS and NHEA	Chapter 3 (introduction); Annex 2
Criteria and interventions	3. Selection of criteria for priority setting	Six criteria (health maximization, disease severity, equity, policy relevance, social impact, feasibility) developed through a four phase process and endorsed by the MoHFS; two additional criteria for Health Promotion and Ayurveda and Alternative Medicine	3.5.1, 3.5.2
	4. Identification of candidate interventions	Desk review of national and global sources; consultations with thematic working groups, experts and stakeholders; clustering into three categories and their clusters	3.3

Phase	Step	Application in Nepal	Section
Financing	5. Assessment of fiscal space	Analysis of health financing sources, fiscal space and public financial management	2.3; 3.5.3 (budget envelope)
	6. Formulation of financing strategies	Budget impact of the prioritized interventions and options for financing basic health services	3.5.3 (budget impact); 4.6; Chapter 5
Analysis and priority setting	7. Evidence generation and analytics	Review and update of evidence on coverage and burden; estimation of local unit costs; cost effectiveness modelling in FairChoices for clinical interventions with effectiveness evidence in the FairChoices database; estimation of budget impact	3.4; 3.5.3
	8. Setting priorities	Provincial and federal deliberations, buffer zone and convergence index; final selection of clinical interventions, with inclusion of those below 0.5 times GDP per capita and of those without a modelled health gain, and consensus on the remaining interventions informed by their budget impact; separate prioritization of Health Promotion and Ayurveda and Alternative Medicine; and validation and endorsement of results, including the level of resources to be committed	3.5.3, 3.5.4
Implementation and monitoring	9. Implementation arrangements	Revision of the BHSP, institutionalization, operationalization support structure and health system reforms	5.1; Chapter 6
	10. Monitoring and evaluation	Alignment of the BHS monitoring system and routine information systems with the revised BHSP	Chapter 7

Source: Adapted from Mwalim et al. (2025).[41]

3.3 Mapping and contextualization of health interventions

Health interventions (hereafter referred to as interventions) are operationally defined as the set of procedures, treatments or management actions implemented along the continuum of care, from prevention to cure, rehabilitation or palliation, which target specific health conditions of individuals or populations. Each intervention has a defined pathway of care and is expected to produce measurable outputs or outcomes in terms of improved health or wellbeing at the individual or population level. These interventions represent a component, combination or entirety of health services delivered through facility based or community based platforms.

The list of candidate interventions identified in the first phase includes both existing services currently delivered within the national health system, identified through a review of policy and programme documents, and new or aspirational services that the country aims to introduce. These aspirational interventions were identified through consultations with MoHFS and DoHS officials, relevant subject and thematic experts, and HDPs supporting programme implementation across DoHS divisions and centres. They

are aligned with national, regional and global health commitments.

In practice, certain supportive or enabling services are required for an intervention to be effective and for a health facility to function optimally. While these may not directly produce clinical outcomes, they underpin the delivery of care by ensuring system readiness, sustainability and service quality. They include basic infrastructure and equipment, trained human resources, logistics and other requirements for service delivery, which together create an enabling environment for health facilities to deliver interventions effectively to the populations they serve. These enabling requirements were not listed as separate interventions but were considered part of the health system readiness needed to deliver them. Beyond clinical interventions, a comprehensive list of interventions for the population also includes nonclinical interventions such as health promotion, risk reduction and the promotion of healthier lifestyles.

Mapping and contextualization were undertaken as an iterative rather than a one time process, with the list of interventions revisited as evidence, priorities and system capacities were clarified. This was particularly important in Nepal's federal health system, where interventions need to align with needs, capacities and resources at the federal, provincial and local levels. The process involved repeated internal technical review, review of national documents, and continuous consultation with programme teams in DoHS divisions and centres, which continued alongside the prioritization process.

3.3.1 Desk review

The desk review provided the initial foundation by mapping interventions from government endorsed policy and regulatory documents, including the Public Health Service Act, regulations, directives and related national guidelines. These included the BHSP and its standard treatment protocols, interventions delivered through vertical programmes in the health sector, and the Minimum Service Standards (MSS) for different levels of health facilities, which were then aligned with global evidence sources. Two major references guided this process:

- The Disease Control Priorities, third edition (DCP3)[4] and the *FairChoices Analytics Tool*,[42] which offer a catalogue and taxonomy of cost effective interventions suited to LMICs; and
- The WHO UHC Compendium,[43] which provides a comprehensive structure for organizing health services across all domains of care.

The FairChoices taxonomy was used as a reference for naming and describing interventions, while the list itself was organized according to the BHSP and the programme categories used in Nepal's health system (Section 3.3.3).

3.3.2 Stakeholder consultation

Consultation with thematic working groups

Programme specific thematic working groups under the TWC were engaged, comprising division heads, planning chiefs and programme focal persons from the relevant divisions of the DoHS, along with practising clinicians, surgeons, other health care providers and public health experts representing relevant domains. The primary objective of these consultations was to contextualize the list of candidate interventions, capturing both interventions currently implemented in Nepal and those that, based on

expert judgement and field experience, should be considered for inclusion.

The identification of interventions and subsequent consultations were guided by a shared understanding that this priority setting exercise was intended to support the potential revision of the BHSP. Accordingly, the candidate list focused on services primarily delivered through BHS service delivery units, namely basic health service centres (or equivalent) and below, and basic hospitals (with 5, 10 or 15 beds) or equivalent.

Consultation with independent experts and other stakeholders

Following the initial mapping, a series of structured consultative meetings was held with independent experts, clinical practitioners, academia and HDPs to refine and validate the list of candidate interventions, ensure its comprehensiveness and technical accuracy, and identify the appropriate service delivery platform for each intervention. Subnational consultations with provincial ministries of health (or equivalent), health sciences academies and selected local governments provided field level insights and helped align the interventions with provincial implementation needs. Further meetings were convened as needed to adjust the list as it was refined.

Several multistakeholder consultative workshops were also organized at the national level to present the consolidated list and seek further technical and policy inputs. Recommendations from these workshops were incorporated, and the revised list was reviewed with focal persons from the respective thematic working groups within programme divisions and centres until consensus was reached. The final list of candidate interventions was then prepared through systematic cross verification and consensus across divisions.

The final consolidated list of candidate interventions also encompasses interventions from Ayurveda and other alternative medicine systems. The inclusion of these interventions was guided by several key considerations:

- These services are formally recognized within the PHSR (2020) and form an integral component of the BHSP;[15]
- Nepal possesses a well established service delivery infrastructure for Ayurveda, managed under the Department of Ayurveda and Alternative Medicine, which functions in parallel with the mainstream modern medicine system; and
- Several provincial governments have initiated efforts to strengthen and expand the provision of alternative medicine services, reflecting the pluralistic nature of Nepal's evolving health system.

3.3.3 Clustering of the interventions and removal of duplication

The candidate list of interventions, compiled through the desk review and stakeholder consultations, was systematically checked for duplication, overlaps and inconsistencies. Redundant entries were removed, and similar or closely related interventions were grouped into clusters.

Clustering reflects how health services are organized in Nepal. Most services are not delivered as isolated interventions but through programmes in which related interventions are planned, budgeted, delivered and reported together, as in immunization, maternal and child health, or NCD programmes. Organizing interventions

in the same way kept the priority setting exercise consistent with existing planning and budgeting structures and made it easier to translate decisions into programme design and implementation. It also allowed related interventions, which often share resources and reinforce each other's effects, to be assessed together, made consultations more efficient, and made the results easier to communicate to policymakers.

To facilitate focused consultations with subject matter experts, interventions were grouped into themes, and further into subthemes where needed, with each group reviewed by the relevant thematic working group. Consultations initially grouped interventions into three broad themes (NCDs and injuries; communicable diseases; and RMNCAH-N), which were later expanded and reorganized into the final structure described below.

The final consolidated list was organized into three broad categories: (i) clinical interventions, comprising all modern medicine interventions; (ii) Ayurveda and Alternative Medicine; and (iii) Health Promotion. Clinical interventions were further grouped into six clusters, and Ayurveda and Alternative Medicine into four subclusters (Table 6). The clinical clusters broadly follow the categories of basic health services defined in the PHSR (Table 1); geriatric and injury related interventions, which do not form separate clusters, were included under the Noncommunicable Diseases and Disability and the General Emergency Services clusters as appropriate. In total, the final list comprised 300 candidate interventions (204 clinical, 60 Ayurveda and Alternative Medicine and 36 Health Promotion interventions), which are listed in full in Annex 3.

Table 6: Candidate interventions by category and cluster

Category	Cluster or subcluster	No. of interventions
Clinical	Immunization Services	12
	Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition (RMNCAH-N)	40
	Communicable Diseases	72
	Noncommunicable Diseases and Disability	49
	Mental Health Services	12
	General Emergency Services	19
	Subtotal	204
Ayurveda and Alternative Medicine	Ayurveda (including yoga)	23
	Naturopathy	14
	Acupuncture (including acupressure and cupping)	11
	Homeopathy	12
	Subtotal	60
Health Promotion	Not applicable	36
Total		300

3.4 Costing of interventions

3.4.1 Approach and scope

Unit costs that accurately reflect the resources needed to deliver each intervention are essential for estimating the cost effectiveness and budget impact of interventions. Ideally, unit costs would be estimated through facility based micro costing that captures observed, intervention specific resource use; however, this approach is highly time intensive and resource intensive and was not feasible for the large number of interventions considered. Unit costs were therefore estimated using a normative, ingredient based (bottom up) costing approach from the provider's perspective, in which all resources required to deliver each intervention through government health facilities were systematically identified, quantified and valued. Cost components were defined to be mutually exclusive, so that no item was counted twice, and exhaustive, so that all relevant resources were captured.

Of the 300 interventions in the candidate list (Table 6), all 204 clinical interventions were costed as 224 care pathways (an intervention was divided into pathways where it covers more than one condition or method), and each pathway has an estimated population in need and target coverage and, where data allowed, current coverage, so that its annual cost could be estimated. For the 60 Ayurveda and Alternative Medicine interventions, only unit costs were estimated, and the 36 Health Promotion interventions were not costed. Headings that group related interventions were not costed separately, and duplicated interventions were removed before costing (Section 3.3.3).

Data sources

For clinical interventions, cost estimates combined several data sources. Prices of medicines and consumables were obtained from federal and provincial government procurement records, supplemented by cost estimates from other sources such as Gavi and costed implementation plans of the MoHFS. To ensure that prices reflected routine service delivery, procurement prices were cross checked against prevailing market prices listed by online pharmaceutical retailers in Nepal, and prices that were unusually high because of exceptional purchasing circumstances, such as during the COVID-19 pandemic, were adjusted. Secondary data were complemented by expert elicitation, particularly for interventions not covered by standard treatment protocols (STPs)[44] or the FairChoices database.

3.4.2 Estimation of unit costs

Costing followed three sequential steps: the identification, quantification and valuation of inputs. The inputs required for each intervention were identified from the STPs or, where these were silent, from expert advice; quantities were estimated for a complete course of treatment (per patient per year for NCDs), with separate components for children and adults where regimens differ, as for tuberculosis; and each input was valued using the rules in Table 7. Estimates reflect a typical service user receiving standard care, adjusted for the expected share of complicated or severe cases, and standardized input sets for common procedures (for example, catheterization and intravenous infusion sets) were costed once and applied across interventions. Unit costs are in NPR at 2025 prices; inflation was applied only in the budget impact analysis (Section 3.5.3).

Table 7: Calculation and valuation of unit costs for clinical interventions

Component	Calculation per case	Valuation and parameters
Medicines and consumables	Quantity per treated case × proportion of cases × unit price × (1 + wastage)	Procurement price lists; wastage 10% for expiry, breakage, storage and distribution
Laboratory tests and procedures	Quantity × proportion of cases × unit price	National Public Health Laboratory; public hospital tariffs or health insurance rates; no wastage
Health worker time	Visit rate × first visits × (minutes per first visit ÷ 15) × (1 + follow up visits × follow up share)	NPR 150 per 15 minutes at every level of care, derived from WHO-CHOICE;45 follow up visit at 50% of a first visit; shorter visits pro rata; 15 minutes where no time is recorded
Inpatient days	Proportion admitted × length of stay × bed day rate	Inpatient care at BHS facilities; NPR 300 per bed day, based on general ward bed charges at public teaching hospitals (B.P. Koirala Institute of Health Sciences and Tribhuvan University Teaching Hospital)46
Referral	Not included	Patients are assumed to enter at the lowest level of BHS and to be referred when needed
Equipment, overheads and contingency	Added to unit costs	10% overhead on health worker time and 5% contingency on all other inputs (medicines and consumables after the 10% wastage, tests, procedures and inpatient days); equipment and referral costs excluded. In the cost effectiveness analysis, FairChoices adds its own markups for facility and above facility costs (Section 3.4.5)
Unit cost of the intervention	Cost of inputs already provided + cost of additional inputs	Each input is classed as already provided in the current package or as additional, which allows the annual cost to be split (Section 3.4.3)

Note: Equipment could be annualized over its useful life at a 3% discount rate if included later. Low, base and high prices are identical in this version, so no price range is reported.

Ayurveda and Alternative Medicine interventions were costed with the same approach, with inputs and local prices based almost entirely on the judgement of practitioners and experts in Nepal, as no reference source such as WHO-CHOICE exists for these services; only unit costs were estimated, because populations in need and targets have not been set. Health Promotion interventions, for which no itemized list of inputs was available, were not costed.

3.4.3 Population in need, coverage and annual cost

The population in need was estimated for each intervention. Where an intervention is divided into components, such as individual contraceptive methods, the population in need of the main intervention was shared among the components in proportion to their use, and for conditions managed as episodes, the number of episodes was used. Current coverage is utilization divided by the population in need and was not

estimated where utilization was missing or not comparable. Target coverage was set for each intervention, taken from the main intervention where none was set for a component, and never below current coverage. The population in need counts people or episodes rather than service contacts: repeat contacts, such as antenatal visits or follow up visits for chronic conditions, are part of the unit cost per case or per person per year (Table 7), so coverage expresses the share of the population in need that receives the full pathway. Current coverage was taken from HMIS or survey data where available and otherwise from programme information and expert judgement (Section 8.2), and monitoring baselines should use the same denominators (Section 7.2). Long acting contraception is costed per insertion over the life of the device (implant five years, intrauterine contraceptive device ten years). The annual cost at target and its components were calculated as:

i) **Total cost of the intervention at target** = population in need of the intervention × target coverage × unit cost;

ii) **Baseline** = population in need × current coverage × current component + population in need × additional services already provided;

iii) **Coverage expansion** = population in need × (target coverage − current coverage) × current component; and

iv) **Additional services** = population in need × target coverage × additional component − population in need × additional services already provided.

The components add up to the total at target, which was checked for every intervention; where current coverage could not be estimated, only the total is reported. The result is the annual cost once every pathway has reached its target coverage, in constant 2025 prices. For the budget impact analysis, these components were projected year by year from 2026 to 2031 (Section 3.5.3).

3.4.4 Assumptions and sensitivity analysis

Where no data existed, a reasoned value was used (Table 8). The base case assumes that patients attend BHS first. The sensitivity analysis assumes that a share x of patients (10%, 20% or 30%, the upper value matching the working group assumption for direct entry at basic hospitals) attend a higher level facility where care costs y more (25%, 50% or 100%), multiplying the cost of all clinical inputs except admissions and equipment by (1 + x × y). Results are reported in Section 4.6.

Table 8: Main assumptions of the costing

Assumption	Value used	Plausible range
Price year	NPR at 2025 prices; in the budget impact analysis only, prices rise by 5% a year from the 2025 level (index 1.05 in 2026)	Not applicable
Base year and horizon	2026 at current coverage; projection to 2031	Not applicable
Referral costs	Excluded; patients enter at the lowest level of BHS and are referred when needed	Sensitivity analysis

Assumption	Value used	Plausible range
Wastage of medicines and consumables	10%, a single rate (no data by item)	5% to 15%
Overheads, equipment and contingency	10% overhead on health worker time and 5% contingency on all other inputs, applied after wastage; equipment not included. FairChoices markups for facility costs (7.4%, the health centre rate, on every cost row) and above facility costs (17%) apply only in the cost effectiveness analysis	Overhead 0% to 15%; contingency 0% to 15%. Without either, the annual cost at target would be about NPR 4.2 billion lower
Lump sum items not itemized (mainly vaccine consumables, 11 interventions)	Kept in the total to avoid understating cost	Not applicable
Targets and populations set by the costing team	Working assumptions (median target 80%; range 20% to 100%)	Not applicable
Screening interventions	Current programme volume, not population wide screening	Not applicable
Long acting contraception	One insertion per device life: implant 5 years, IUCD 10 years	Implant 3 years; IUCD 5 years
Palliative care medicines for home based care of people living with HIV	One bundle per person per year	0 to 1 bundle
Four items without a price	Price of the closest comparable item (for example, chest X-ray tariff of NPR 500 for artificial intelligence assisted radiography)	Well under NPR 0.1 billion in total
Sterilization in FairChoices	Cost spread over 15 years of protection	10 to 20 years
Ayurveda: combined interventions	Equal weight to the two sets of inputs	25/75 to 75/25
Ayurveda: group sessions (for example, yoga)	Costed as individual consultations (upper bound)	About 1/20 of the visit cost for groups of 20

3.4.5 Inputs to the cost effectiveness analysis

Unit costs and coverage from the costing were entered into FairChoices,42 which provides the estimates of effectiveness and the demographic and epidemiological model (Section 3.5.3):

- **Linking:** Each of the 224 clinical pathways was compared with the interventions in the FairChoices database, and 92 pathways could be linked, fully or in part where Nepal delivers only part of the service, to 82 FairChoices interventions for which health gains are modelled; these were analysed to estimate the cost per healthy life year gained. A further 16 pathways, mostly family planning, were linked to 11 FairChoices interventions for which no health gain is modelled, because their effect operates through fertility or is not captured in the model. The remaining 116 pathways have no comparable intervention in the FairChoices database, so effectiveness data were not available for them in this round. Where one FairChoices intervention corresponds to several

Nepal pathways, such as newborn care, the costs of the component pathways were used. Where one Nepal pathway corresponds to several FairChoices interventions, such as the syndromic management of sexually transmitted infections, each FairChoices intervention was analysed separately and the pathway was assigned the cost effectiveness band of its best ranked linked intervention; for all six such pathways, a pooled ratio (the sum of incremental costs divided by the sum of healthy life years gained) gives the same band. The cost effectiveness results for each linked Nepal intervention are given in Annex 6.

- **Costs:** All costs in the analysis are Nepal unit costs. Where part of a FairChoices intervention has no counterpart in the Nepal pathway, that part was given no cost, while the health gain modelled in FairChoices was kept. Components of FairChoices interventions that lie outside the Nepal pathways, namely insulin treatment within the management of type 2 diabetes, the management of hyperglycaemia in pregnancy within antenatal care and epilation within the treatment of trachoma, were also left out. For newborn screening for sickle cell disease, only the costs of the visit and the tests were used. For each matched Nepal intervention, its unit cost was applied in FairChoices in place of the default cost per person treated, while FairChoices was used to estimate the number of people treated and the resulting health gains. Where a FairChoices intervention corresponds to several Nepal interventions, their unit costs were averaged, weighted by the number of people treated, and costs already included in another Nepal unit cost were not counted again. Long acting contraception uses the cost per user year, and sterilization is spread over 15 years.

- **Prices:** Costs were converted at NPR 137.0 per US dollar, the buying rate of Nepal Rastra Bank in mid July 2025, used as the mid year rate for 2025,[47] and include the FairChoices markups for facility costs at the health centre rate (7.4%) and above facility costs (17%), applied to every cost row whatever its delivery platform in FairChoices, on top of the Nepal unit costs, which already include the overhead and contingency (Section 3.4.2). Cost effectiveness ratios are reported in US dollars at 2024 prices, the price base of FairChoices and the year of the GDP per capita against which they are compared.

- **Coverage and time horizon:** Nepal interventions that match a FairChoices intervention, fully or in part, use their own current and target coverage (current coverage capped at 98%), weighted by the population in need; for early care for newborns, coverage is taken from essential newborn care (63% rising to 90%). Coverage rises in equal annual steps from 2026 to the target in 2031, in line with the budget impact analysis, without discounting, and the population in need comes from the GBD Study 2023[19] and the World Population Prospects.[48]

- **Measures:** Healthy life years gained, incremental cost, the cost per healthy life year gained and, as a measure of disease severity, the health adjusted age at death (HAAD) of those who benefit, with the equity rank derived from it (Section 3.5.2). Interventions were grouped into two bands relative to GDP per capita (US$1,447.7

in 2024): less than 0.5 times, and 0.5 times GDP per capita or more. Partial matches are flagged, because their estimates cover only part of the Nepal pathway, and are presented in a separate table.

Pathways (clinical interventions) without a modelled health gain, whether linked to FairChoices or not, have unit costs and budget impact estimates but no cost per healthy life year gained.

3.4.6 Estimation of budget impact

Two cost measures were produced, and they answer different questions. The BHS costing gives the annual cost of each clinical pathway for Nepal's population in need, in NPR, from 2026 to 2031, divided into (a) the cost of current BHS interventions at current coverage, (b) the additional cost of scaling them up to target coverage, and (c) the cost of additional services not yet provided. Summed with each pathway counted once, it is the basis for the resource requirement of the package (Sections 4.6 and 5.2), and it can also be accumulated in the order of the cost effectiveness ranking or of the priority groups agreed through consensus to show the cost of packages of different sizes. For the Nepal interventions analysed in FairChoices, the tool also estimates an incremental cost of scale up, but this is used only to calculate the cost per healthy life year gained and is not a measure of budget impact; the resource requirement of the package is based on the BHS costing alone. The approach for Ayurveda and Alternative Medicine and Health Promotion is described under Budget impact analysis in Section 3.5.3.

3.5 Prioritization of interventions

Prioritization followed a common set of criteria (Section 3.5.2), but the way these were applied differed across the three categories of interventions described in Section 3.3.3, reflecting differences in the availability of evidence on effectiveness and cost effectiveness.

- **Clinical interventions:** For the 92 of the 224 clinical pathways that could be linked to a FairChoices intervention with modelled health gains (Section 3.4.5), health maximization and disease severity were assessed quantitatively by estimating the cost per healthy life year gained using the FairChoices tool, together with the health adjusted age at death as a measure of severity (Section 3.5.3). For the remaining 132 pathways, cost effectiveness was not estimated: 16 are linked to FairChoices interventions for which no health gain is modelled, mainly family planning, and for the other 116, effectiveness evidence suitable for modelling was not available in this round. These pathways were assessed on their estimated budget impact together with the qualitative criteria. For both groups, the quantitative estimates were considered alongside equity, policy relevance, social impact and feasibility through structured deliberation, which formed a separate and complementary component of the priority setting process. In the final selection, pathways linked to interventions costing less than 0.5 times GDP per capita per healthy life year gained, and those linked to FairChoices interventions without a modelled health gain, mainly family planning, were included, while the remaining pathways were decided on their budget impact and the qualitative criteria through consensus with national level stakeholders (Section 3.5.3).

- **Health Promotion:** Because evidence on the effectiveness and cost effectiveness of promotive interventions is generally limited or highly context specific, these interventions were prioritized through structured deliberation, supported by a structured multicriteria assessment that applied the qualitative criteria together with the additional criteria of preventive value and positive externalities (Sections 3.5.2 and 3.5.3).
- **Ayurveda and Alternative Medicine:** Unit costs were estimated for these interventions, but evidence on their effectiveness, coverage and the population in need was not available for this exercise, so cost effectiveness could not be estimated in this round. These interventions were therefore prioritized largely through qualitative methods, involving a series of consultations and deliberations with relevant experts, government officials and other stakeholders.

3.5.1 Development of prioritization criteria

After mapping available interventions, prioritization was conducted using predefined criteria developed through a four phase, systematic process to ensure contextual relevance and an evidence base (Figure 12). Phase 1 involved a literature review and stakeholder led identification of potential criteria through workshops and interviews across provinces. In Phase 2, these criteria were consolidated, reviewed and grouped through consultations with DoHS divisions, academics and sector experts to ensure strategic alignment. Phase 3 focused on multilevel validation through provincial and local consultations, a joint workshop and an online survey of diverse stakeholders. In Phase 4, the finalized criteria were reviewed and formally endorsed by the TWC and the Steering Committee of the Ministry and subsequently approved at the level of the Secretary.



Figure 12: Process adopted in development of prioritization criteria

3.5.2 Prioritization criteria

The six criteria for prioritization of interventions were health maximization, disease severity, equity, policy relevance, social impact and feasibility (Figure 13). Together, they provided a structured framework for comparing interventions not only in terms of their health outcomes but also in terms of their broader social and policy implications.

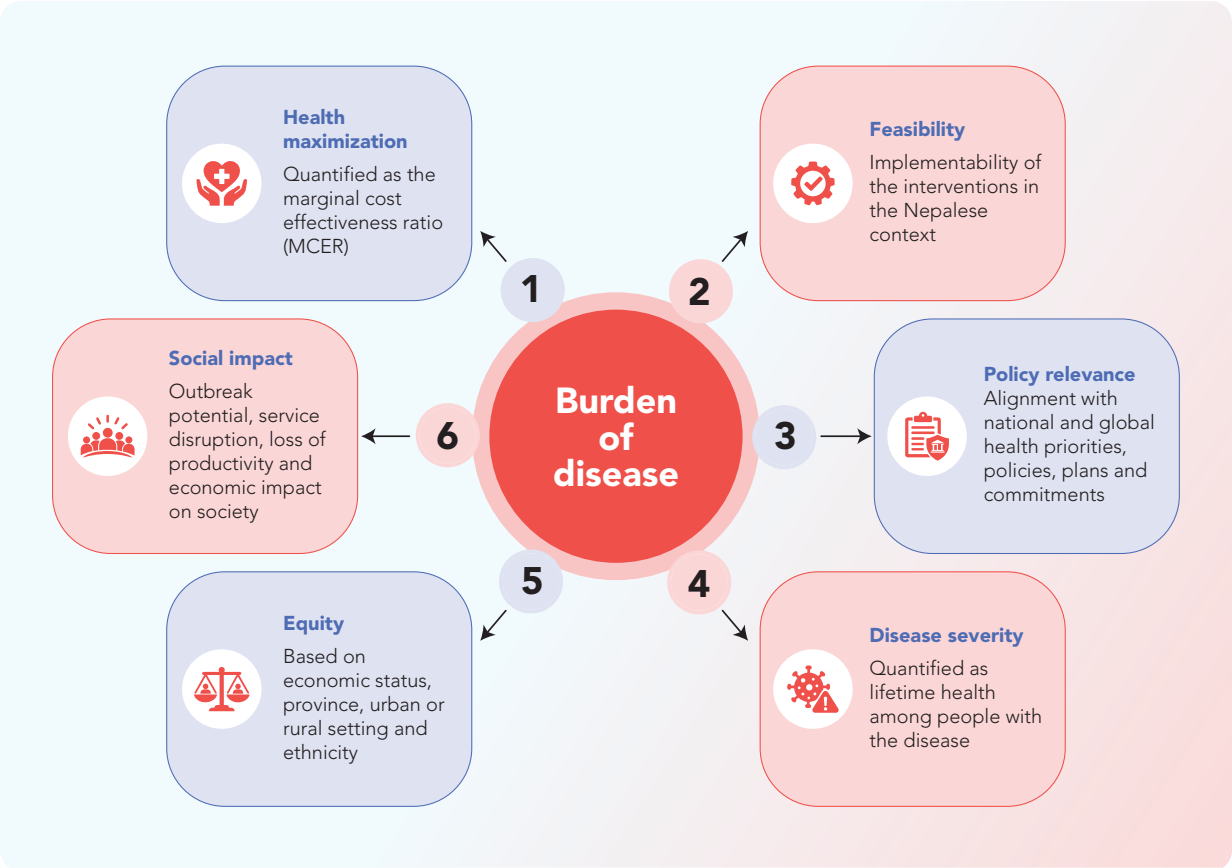


Figure 13: Criteria for prioritization of health interventions in Nepal

drawing on national and global evidence on intervention costs, the population in need, effectiveness and the quality of available evidence. Because resources are limited, this criterion helps to ensure that the package delivers the greatest possible health gain for the budget available. Where cost effectiveness could not be estimated, this criterion was considered qualitatively during deliberation, informed by estimates of budget impact.

Health maximization

Health maximization aims to achieve the greatest total improvement in population health from the resources available, by favouring interventions that deliver the largest health benefits relative to their costs. It was assessed using the marginal cost effectiveness ratio (MCER), the additional cost per healthy life year gained from increasing the coverage of an intervention,

Disease severity

This criterion is measured by the health adjusted age at death (HAAD), the number of healthy life years that people with the condition are

expected to experience over their lifetime if the condition remains untreated.[49] It consists of two components: past health (before onset of the condition) and expected future health (after onset).

A lower HAAD indicates a more severe condition, one that causes a greater loss of lifetime health, usually because it strikes early in life. FairChoices reports the HAAD of the people who benefit from each intervention with a modelled health gain and uses it to give greater weight to health gains for those who are worse off: gains for conditions with a low HAAD, typically those affecting people before middle age, receive the highest weight, gains for conditions with a HAAD in older age receive a weight of one, and the weight declines linearly with HAAD between these two points.[42] The weighted gains are used to derive an equity rank for each intervention. The design of the prioritization process provided for cost effectiveness ratios adjusted for severity to be used in deliberation (Figure 14); in the final analysis, the ratios are reported without weighting, together with the HAAD and the equity rank, so that severity is considered alongside the ratio rather than built into it (Section 4.2.3).

Including severity ensures that priority setting goes beyond efficiency alone. Without it, interventions for less severe conditions with favourable cost effectiveness could be ranked above those addressing conditions that cause greater lifetime health loss. The HAAD and the equity rank are reported for every intervention for which cost effectiveness was estimated (Annex 6).

Equity

This criterion prioritizes interventions that benefit disadvantaged or underprivileged groups, considering economic status (poverty), geographical location or province, urban or rural setting, and ethnicity. Interventions that disproportionately benefit underprivileged population groups, and thus help to narrow the equity gap, are considered desirable according to this criterion:

a) **Economic status (poverty):** the intervention provides disproportionate benefit to people living in poverty, who often face a higher disease burden, lower access to services and greater financial vulnerability.

b) **Geographical location or province:** the intervention addresses inequities linked to geographical disparities, such as remote, mountainous or underserved provinces with limited health infrastructure.

c) **Rural or urban setting:** the intervention helps to reduce differences in access or outcomes between rural and urban populations; rural areas often have fewer health facilities, longer travel times and lower service availability.

d) **Ethnicity:** the intervention benefits ethnic or socially marginalized groups who experience a disproportionate disease burden, cultural barriers, discrimination or lower service uptake.

Incorporating equity ensures that resource allocation is guided not only by efficiency but also by fairness, so that disadvantaged groups are not left behind even as overall population health improves, in line with Nepal's commitment to UHC.

Policy relevance

Policy relevance refers to the extent to which an intervention aligns with and

contributes to achieving national or global health priorities, policies and goals, such as UHC and the Sustainable Development Goals (SDGs). It was analysed considering the following:

a) **Contribution to national and international goals and commitments:** the intervention directly supports national health priorities, such as those outlined in Nepal's national health policies, periodic development plans, disease control programmes or essential service commitments.

b) **Sustaining achieved goals:** the intervention helps to protect, maintain or prevent backsliding on health achievements that Nepal has already realized (for example, immunization coverage, reduction of maternal mortality and disease elimination targets).

c) **Potential for future policy buy in:** the intervention has a high likelihood of gaining political, administrative or public support in the future; this may include emerging health priorities, innovations or interventions currently under discussion.

Even highly cost effective interventions may not be adopted, funded or sustained if they are not aligned with policy directions or lack institutional support. This criterion therefore helps to bridge technical analysis and policy implementation.

Social impact

Social impact refers to the broader consequences of health conditions for the wellbeing of individuals, households, communities and society beyond their direct health effects, and to the extent to which an intervention can prevent or reduce these consequences. It was assessed across four dimensions:

a) **Potential for population level spread and outbreaks:** whether the condition can spread widely in the community, and whether the intervention (for example, vaccination, surveillance or early treatment) can prevent or contain outbreaks.

b) **Potential to disrupt essential services:** whether the condition can interrupt health care, education, transport or other essential services, and whether the intervention can help to maintain their continuity.

c) **Productivity loss over a longer period (more than six months):** whether the condition leads to prolonged disability or inability to work or take part in social activities, and whether the intervention can reduce long term morbidity and restore productivity.

d) **Potential for catastrophic expenditure:** whether the condition exposes individuals or households to very high OOP costs, and whether the intervention can reduce this financial burden through prevention or early treatment.

Considering social impact ensures that interventions are valued not only for their direct health gains but also for the wider social and economic protection they provide, including continuity of essential services and protection of households from financial hardship.

Feasibility

Feasibility refers to the extent to which a health intervention can be realistically implemented within the existing health system. It assesses whether the required structures, resources and enabling environment

are in place, or can reasonably be established, to support effective, safe and sustained delivery of the intervention. It was assessed across four interrelated dimensions:

a) **Administrative feasibility:** the capacity of the health system to implement an intervention, considering the availability of human resources, organizational structures and time; it also assesses the ability to monitor and evaluate implementation and takes into account potential barriers to coordination and execution.

b) **Technical feasibility:** whether the required technology, infrastructure and technical expertise are available to support the intervention; it further considers compatibility with existing systems and the potential for scale up within the current health system.

c) **Political and social feasibility:** the degree of political support and alignment with existing political, cultural and social contexts; it also considers public and stakeholder perceptions, social acceptance and the cultural appropriateness of the intervention.

d) **Legal feasibility:** whether the intervention complies with relevant ethical standards and legal requirements, including alignment with local, national and international regulations, and the potential risk of legal issues arising during implementation.

Even highly effective interventions cannot generate health gains if they cannot be delivered in practice. Including feasibility grounds prioritization in the realities of Nepal's health system and helps to identify interventions that are not only desirable but also implementable and sustainable.

Additional criteria for Health Promotion and Ayurveda and Alternative Medicine interventions

For Health Promotion and Ayurveda and Alternative Medicine interventions, health maximization and disease severity could not be quantified, for the reasons set out at the start of Section 3.5: the effects of Health Promotion interventions often operate indirectly and over the long term, and evidence on effectiveness, coverage and the population in need was not available for Ayurveda and Alternative Medicine in this round. In their place, two additional criteria were considered:

- **Preventive value:** the anticipated health gains from reducing the risk of disease, injury or other adverse health outcomes before they occur, including the potential to prevent future morbidity, mortality and health care costs.

- **Positive externalities:** benefits that extend beyond the direct recipients of an intervention, such as reduced transmission of communicable diseases, improved community awareness and wider social and economic gains.

These two criteria, together with the qualitative criteria of equity, policy relevance, social impact and feasibility as applicable, informed the deliberations through which these interventions were prioritized (Section 3.5.3). In the absence of quantitative evidence, they were assessed through expert and stakeholder judgement; for Health Promotion, this judgement was supported by the structured multicriteria assessment described in Section 3.5.3. As evidence on effectiveness, coverage and the

population in need becomes available, the cost effectiveness of interventions in both categories can be assessed in future iterations of the priority setting process.

3.5.3 Process for prioritization of interventions

The burden of disease forms the foundation of this priority setting process. National burden of disease estimates for Nepal from the GBD Study 2023, presented in Section 2.1, provide the baseline for identifying the health problems that require the most urgent attention and for assessing which interventions could yield the greatest population health gains.

Review and update of the evidence

A major methodological step in the prioritization process was the collection of information and background evidence on interventions. For each of the defined interventions, baseline and target coverage were identified. This work involved collating information from multiple sources, including the HMIS, national surveys, programme reports and, where necessary, expert consultations. Demographic and epidemiological data were drawn from established sources, including the United Nations World Population Prospects[48] and the GBD Study.[19] Although default cost estimates for LMIC settings were available in the FairChoices database, locally relevant unit costs were estimated for this exercise, as described below. This process was guided by data availability and carried out in consultation with relevant local experts.

Estimation of the budget envelope

The budget envelope was defined as the public resources available for BHS and was estimated from the approved annual work plan and budget (AWPB) of the MoHFS for FY 2080/81 to 2083/84 (2023/24 to 2026/27).[28] The source data comprised 106,015 budget lines covering the federal health budget and the conditional grants it transfers to the seven provinces and 753 local levels. Allocations that provinces and local levels make from their own revenue or equalization grants, health insurance claims and household spending were outside the scope. Every budget line was classified using documented rules applied to its activity description, programme, budget head and economic code, so that each classification can be traced back to the source.

BHS were defined as all allocations to local levels, which are constitutionally responsible for BHS, together with federal and provincial procurement of medicines, vaccines, programme medicines, nutrition supplements and contraceptives for basic services (Table 9). The monthly cash support of NPR 5,000 for patients with kidney failure, cancer or spinal injury, which is routed through local levels, was excluded as support for specialized care. Separate envelopes were estimated for Ayurveda and Alternative Medicine and for health promotion and preventive services, the latter following the preventive care function (HC.6) of the System of Health Accounts 2011. The categories overlap, as local immunization and FCHV allocations, for example, belong to both BHS and health promotion, so they are not additive.

The envelope was projected for five years, FY 2084/85 to 2088/89 (2027/28 to 2031/32), covering the scale up of the package to its targets in 2031, using three methods: compound growth at the rate observed over FY 2080/81 to 2083/84; a linear trend fitted to the four years; and a share based method, in which the projected total health budget is multiplied by

each category's four year average share. The share based method was used as the central estimate, because category amounts fluctuate with campaign years while their shares are more stable, and the range across the three methods is reported as the uncertainty band. Projections are nominal and are also expressed at constant FY 2083/84 prices using an illustrative inflation rate of 5% a year. They assume that the current allocation pattern continues, with no new reform or reallocation, and they reflect approved allocations rather than expenditure. The resulting envelope is presented in Section 4.6.2.

Table 9: Definitions of the budget envelopes

Envelope	Included	Excluded
Basic health services (core)	All allocations to the 753 local levels; federal and provincial procurement of essential and emergency medicines, vaccines, programme medicines (TB, HIV, IMNCI, NCD), nutrition supplements and contraceptives	Monthly NPR 5,000 support for kidney, cancer and spinal injury patients; medicines for hospitals, specialized care, epidemic stockpiles and regulators
Basic health services (extended)	Core, plus federal and provincial procurement of diagnostics and other public health commodities	As for core
Ayurveda and Alternative Medicine	Budget heads and programmes of Ayurveda, homeopathy, naturopathy, yoga, Amchi and Unani services; Ayurveda basic health services are the part within BHS core	Lines that combine Ayurveda with other facilities in one amount (mainly the local salary line), so the total is understated
Health promotion and preventive services	Immunization; health education, information and communication; disease prevention and surveillance; screening; nutrition promotion and supplementation; FCHV and school health	Construction, equipment, grants to hospitals, treatment purchases, family planning, Aama incentives and CBIMNCI case management

Modelling of quantitative criteria in the FairChoices tool

To assist priority setting across a large set of health interventions, the FairChoices Analytics Tool (www.fairchoices.org)[42] was used. FairChoices is a decision support platform designed to inform health benefit package design, especially in LMICs, by linking intervention scale up to population health gains and costs. The tool was developed by a team within BCEPS in collaboration with the Disease Control Priorities team at the University of Washington to help countries make fair, evidence informed and cost effective choices in health policy and planning.

The platform includes three main components:

1. An evidence tool (input tool) for data entry and updates;
2. A validation tool to ensure the quality of local data and consistency with the global model; and
3. A health benefits package tool that forecasts costs and health effects.

The analytic engine of FairChoices is a deterministic population model that, in its default form, combines demographic and epidemiological parameters from international sources with evidence from the literature on

intervention effectiveness, coverage and cost. In practical terms, the model predicts how mortality, disability and costs change if the coverage of a given intervention increases over time, for example from a current baseline to a target level.

The health impact component uses a lifetime perspective of health. Based on age and sex specific mortality rates and disability rates, the model estimates healthy years gained and statistical lives saved by comparing a baseline scenario with an adjusted scenario in which interventions are scaled up.

To estimate healthy years gained, the model subtracts health adjusted life expectancy (HALE) at baseline from HALE after interventions are scaled up, for each birth cohort:

$$\Delta HY_c = HALE_{c,adjusted} - HALE_{c,baseline}$$

where *c* denotes a cohort, that is, everyone born in the same year. The total health gain is the sum over all cohorts:

$$\Delta HY = \sum_c \Delta HY_c$$

Statistical lives saved, ΔSLS_c, are calculated in the same way for each cohort and summed over all cohorts to give the total.

The model draws on the World Population Prospects for demographic inputs and the GBD Study for epidemiological inputs, while effectiveness parameters come from the published literature and other evidence sources. Importantly, FairChoices does not treat all interventions identically; it applies different effectiveness models depending on the nature of the intervention and the targeted condition, including treatment of acute conditions, prevention with delayed benefits, treatment of chronic conditions, treatment of nondeadly conditions, family planning, and interventions that indirectly affect the targeted condition through improved access or quality rather than direct health gains.

Contextualization to each country's health system, data environment and policy priorities is a core element of the FairChoices tool, ensuring that analytical outputs are relevant, credible and actionable for local decision makers. In the current priority setting process, contextualization involved several complementary activities, including updating the nationally available or estimated baseline coverage of interventions, incorporating locally estimated unit costs (as described above) and updating target coverage on the basis of national goals and targets. The national FairChoices team in Nepal worked closely with all relevant sections within the divisions and centres of the DoHS and the MoHFS to tailor the tool so that it accurately reflects country specific service delivery platforms, baseline coverage levels, intervention effectiveness and costs. Estimates of costs, effectiveness and coverage were reviewed and refined iteratively until contextualization was completed and the final MCERs were generated.

Using the FairChoices framework, data on intervention costs, effectiveness, population in need and health outcomes were modelled to estimate the cost per healthy life year gained for each clinical pathway linked to a FairChoices intervention with modelled health gains, together with the HAAD and the equity rank as measures of disease severity (Section 3.5.2). This modelling addressed the first two priority setting criteria: health maximization and disease severity.

Cost effectiveness was estimated for clinical interventions that could be linked to an intervention in the FairChoices main tool, using the effectiveness evidence in the FairChoices database together with locally updated baseline coverage, target coverage and unit costs. For pathways linked to FairChoices interventions in which no health gain is modelled, mainly family planning, only costs are reported. For the pathways with no FairChoices match, effectiveness evidence suitable for modelling was not available in this round, so cost effectiveness was not estimated for them. These interventions have unit costs and budget impact estimates but no cost per healthy life year gained, and their cost effectiveness can be assessed in future rounds as evidence becomes available (Section 6.2.2).

Contextualization is an ongoing process, and the tool can be updated as new local evidence on coverage, costs and effectiveness becomes available (Section 6.2.2).

Budget impact analysis

The budget impact analysis estimated the resources required to deliver the prioritized interventions at current coverage and at target coverage and compared these requirements with the budget envelope. For each clinical intervention, the annual cost is the product of the unit cost, the population in need and coverage, taken from the BHS costing (Section 3.4.3): the cost at current coverage is the baseline, the cost at target coverage is the annual requirement once targets are reached, and the difference between the two is the incremental cost of scale up. The annual cost was projected from 2026, the base year at current coverage, to 2031. Coverage rises in five equal annual steps, closing a fifth of the gap each year, to reach the target in 2031, so that 2027 to 2031 corresponds to the five fiscal years of the projected envelope, FY 2084/85 to 2088/89. The population in need was held constant, as total fertility in Nepal is below replacement level. Costs are reported in nominal terms, with unit costs inflated by 5% a year from the 2025 price level (a factor of 1.05 in 2026), and at constant 2025 prices. Each year's cost is divided into the three components described in Section 3.4.6: current BHS interventions at current coverage, scale up to target, and additional services not yet provided. The incremental cost of scale up estimated in FairChoices was used only in the cost effectiveness analysis and is not added to these costs (Section 3.4.6).

Ayurveda and Alternative Medicine and Health Promotion interventions were handled differently, because the population in need and coverage were not available for them (Section 4.2.1). For Ayurveda and Alternative Medicine, unit costs were estimated, but the budget requirement was based on the allocation for Ayurveda services within the BHS envelope identified in the budget analysis (NPR 452 million in FY 2083/84), projected with the same methods as the BHS envelope. Health Promotion interventions were not costed, and their budget requirement was based on the allocation for health promotion and preventive services (NPR 8.2 billion in FY 2083/84).[28] A constant marginal cost was assumed as coverage increases (Section 8.2).

The cost of clinical interventions for 2027 to 2031 was compared with the projected BHS envelope for FY 2084/85 to 2088/89, year by year and over five years, using the central projection together with the range across the three projection methods, in nominal terms and at constant FY

2083/84 prices, and the incremental cost of scale up was compared with the projected growth of the envelope. The comparison is indicative of affordability rather than a match between budget lines: over FY 2080/81 to 2083/84, local health workforce salaries accounted for 57.6% of the BHS envelope, local programmes and service delivery for 17.8%, medicine procurement for 14.7% and capital grants for 9.6%,[28] whereas intervention unit costs value health worker time per service and include medicines, consumables and tests, with a 10% overhead on health worker time and a 5% contingency on other inputs, but exclude equipment (Section 3.4.2).

Cost effectiveness analysis shows that some interventions generate substantial health gains but require considerable resources, while others achieve health gains at a lower cost. Prioritization therefore requires consideration of both the health gains achieved relative to the resources required and the budgetary implications of implementing interventions at scale: cost effectiveness analysis helps to assess value for money, while affordability depends on the resources available and the total cost of implementation. In this exercise the budget envelope was used in two ways. It was first used to test the affordability of all candidate clinical interventions, as an upper bound, and of the interventions included in the final selection on the grounds of cost effectiveness or established programme commitments. For the remaining interventions, which were placed in priority groups through consensus, the cumulative cost of each successive priority group was set against the projected envelope, so that the Steering Committee could judge how far beyond the resources projected under current allocation patterns it was prepared to go, and therefore which priority groups should enter the package and at what pace (Section 3.5.4). Because cost effectiveness could not be estimated for Health Promotion and Ayurveda and Alternative Medicine interventions, and Health Promotion interventions were not costed, these limitations should be kept in mind when interpreting the estimated resource requirements and the affordability of the package.

Deliberation

Deliberation complemented quantitative analysis by bringing contextual knowledge, values and implementation considerations into the prioritization process. Deliberations were held in several rounds at both the provincial and federal levels. Provincial workshops brought together participants from provincial and local governments, health facilities, HDPs and civil society, while federal workshops involved MoHFS officials, representatives of divisions and centres under the DoHS, thematic experts and representatives of HDPs. The deliberations followed the logic of evidence informed deliberative processes, in which stakeholders appraise the evidence against explicit criteria and record the reasons for their judgements,[5,9] and they aimed at consensus, judged through the convergence index described below.

The deliberations took place while the quantitative analysis was being progressively refined and drew on the cost effectiveness estimates available at the time. These preliminary estimates applied the default unit costs for low and middle income countries in the FairChoices database. In the final analysis they were replaced by locally estimated unit costs (Section 3.4), which changed the cost per healthy life year gained of many interventions and their position in the

ranking. The final estimates are also presented without severity weighting and against GDP per capita for 2024. The insights and recommendations from the deliberations were therefore carried forward as an input to the final selection of clinical interventions described below, rather than applied mechanically to the final ranking, and were considered alongside the final cost effectiveness estimates, where available, and the budget impact estimates in determining the final list of priority interventions, which was then validated and endorsed (Section 3.5.4). The deliberations also helped to update and refine the definitions of some interventions, complementing the iterative technical review and continuous consultation with programme teams through which the list of interventions was developed (Section 3.3).

Several interventions were identified from government rules, regulations and directives, but these were not always consistent with one another in their recommendations for implementation, and many interventions lacked clear and standardized definitions, so that their scope, design and relationships with other interventions were not always well understood. Key issues were determining the appropriate boundaries of basic health services, particularly where clinical services form part of a broader continuum of care, and identifying the appropriate delivery platform for each intervention: in some cases, an intervention included a wide range of services, while in others its scope was too narrow to cover the health care services required. These challenges highlighted the need for a more systematic and coherent approach to defining and designing interventions. Several rounds of individual and group consultations were therefore conducted, at the federal level in particular, to gather feedback, clarify intervention definitions, refine their scope and design, and reach agreement on appropriate delivery platforms, with government officials and technical staff drawing on their practical experience and institutional knowledge to identify feasible and context appropriate arrangements. The list of interventions was then finalized and incorporated into the FairChoices model, together with their estimated costs.

Province level deliberation

Three structured deliberation workshops, one in each province, were held sequentially in Karnali, Sudurpashchim and Lumbini provinces. Each workshop began with an orientation on the prioritization process, progress to date and the inputs expected from participants. For the deliberations, interventions were grouped into three thematic areas: NCDs and injuries; communicable diseases; and RMNCAH-N. Within each theme, and to facilitate comparison and deliberation, interventions were classified into four categories according to their preliminary cost per healthy life year gained, using Nepal's GDP per capita of US$1,363 in 2023 (Table 2) as a reference point:

- **Category A (highly cost effective):** less than US$1,363 per severity adjusted healthy life year gained;
- **Category B (moderately cost effective):** US$1,363–4,089 per severity adjusted healthy life year gained;
- **Category C (less cost effective):** more than US$4,089 per severity adjusted healthy life year gained; and
- **Category D (no cost effectiveness estimate available):** clinical interventions without cost

effectiveness estimates; Health Promotion and Ayurveda and Alternative Medicine interventions.

These categories provided indicative benchmarks for deliberation rather than definitive measures or automatic rules for selecting interventions. GDP per capita does not indicate whether an intervention is affordable within the available health budget; affordability was therefore considered separately, in relation to the resources required for implementation and scale up (see Budget impact analysis above). In the final analysis, the reference point was updated to GDP per capita for 2024 (US$1,447.7), and the estimates were grouped into two bands, less than 0.5 times and 0.5 times GDP per capita or more (Section 3.4.5).

Discussions took place in small thematic groups of purposively selected multisectoral participants, including officials from the provincial Ministry of Health and health directorate, local government health officials, health facility staff, public health professionals, representatives of HDPs and civil society representatives. The groups assessed the feasibility of delivering the interventions at the provincial or local level across the four domains described in Section 3.5.2. Group outputs were presented at a high level debriefing session chaired by the respective provincial Honourable Ministers of Health and attended by senior MoHFS officials, whose observations and policy commitments were also recorded.

The provincial deliberations also contributed to refining the list of candidate interventions, for example by flagging interventions that were not feasible or not appropriate for delivery as part of basic health services.

Federal level deliberation

Building on the provincial deliberations, several rounds of structured deliberation workshops were held at the federal level to consolidate the prioritization of clinical interventions. All clinical interventions with cost effectiveness estimates were ranked together against a reference cutoff of one times GDP per capita (US$1,363; Table 2). To account for uncertainty around this cutoff, a buffer zone was defined, comprising the 15% of ranked interventions immediately below the cutoff and the 15% immediately above it. Interventions were thus grouped into three categories (Figure 14):

- Interventions above the cost effectiveness benchmark, that is, with MCERs below the buffer zone, which were recommended for inclusion;
- Interventions within the buffer zone, which were subject to structured deliberation taking account of additional qualitative criteria; and
- Interventions below the cost effectiveness benchmark, that is, with MCERs beyond the buffer zone on the less cost effective side, which were not recommended for inclusion in this round.

The buffer zone was a deliberative rule rather than a statistical uncertainty interval: it was defined by the number of ranked interventions on either side of the cutoff, not by the uncertainty in their estimated ratios, so its width in cost effectiveness terms depended on how the interventions were distributed around the cutoff. Its purpose was to allow contextual considerations to inform decisions on interventions close to the cutoff, where the ranking is least decisive, and its width of 15% on each side was set as a practical rule

for the deliberations. Interventions within the buffer zone were assessed against the four qualitative criteria of equity, policy relevance, social impact and feasibility, which capture considerations that cost effectiveness alone cannot. In these rounds, deliberation was confined to the buffer zone, and interventions outside it were not reclassified. Equity, legal or feasibility concerns about interventions outside the buffer zone were not set aside: they were carried into the final selection, in which pathways at or above half of GDP per capita and those without an estimate were placed in priority groups through consensus, and pathways in streams A and B flagged in the provincial deliberations were reviewed so that conditions could be attached to them (see Final selection of clinical interventions below). Clinical interventions without cost effectiveness estimates were not included in the ranking or the buffer zone. They were deliberated separately against the four qualitative criteria of equity, policy relevance, social impact and feasibility, and the resulting recommendations were considered together with their estimated budget impact in determining the final list of priority interventions (see Final selection of clinical interventions below). Health Promotion and Ayurveda and Alternative Medicine interventions, for which MCERs were not available, were prioritized separately, as described below. These rounds used the preliminary, severity adjusted estimates; how their outcomes were carried into the final selection, which used the final estimates, is described below.

Use of the convergence index in deliberation

A convergence index (CI) was used to support deliberation on interventions within the buffer zone. Using a locally developed digital platform, participants assessed each intervention against the four qualitative criteria, indicated their choice and documented the reasons underlying their decisions. The CI summarized the degree of agreement among participants for each intervention. Deliberation was conducted over three rounds, allowing participants to reflect on the reasons shared by others and revisit their choices. Capturing both choices and their justifications enhanced transparency

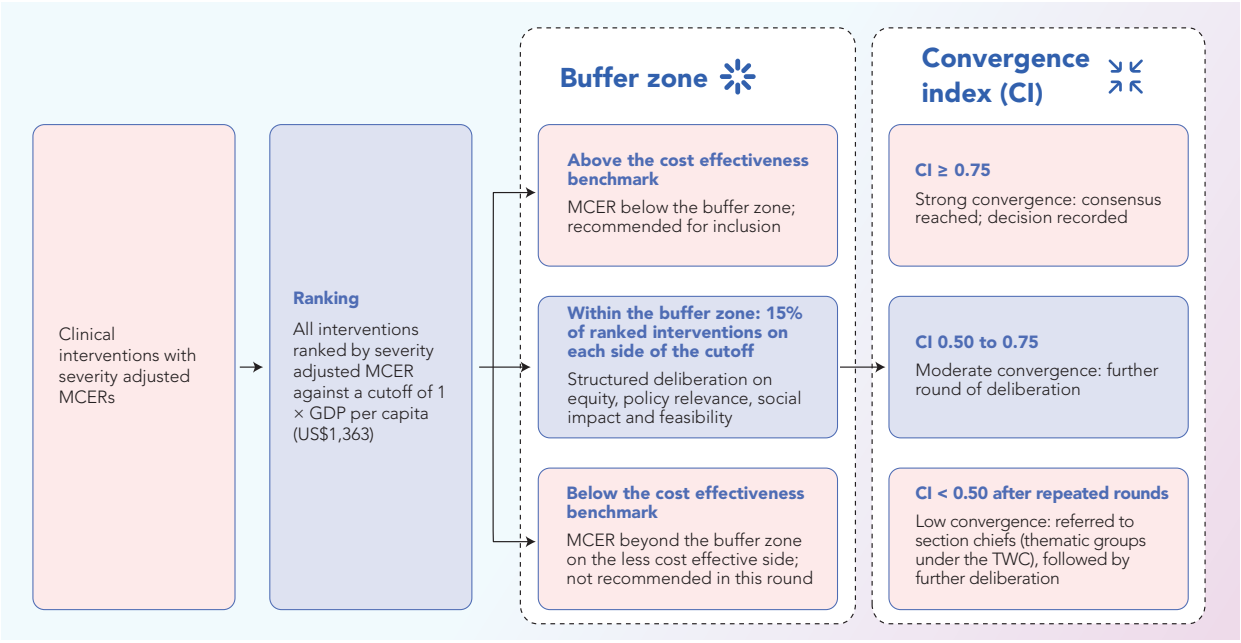


Figure 14: Prioritization process for clinical interventions with cost effectiveness data

and strengthened deliberative rigour beyond simple voting or weighting.

The following CI thresholds guided the interpretation of agreement: strong convergence (CI ≥ 0.75) indicated a high level of agreement among participants and was taken to represent consensus; moderate convergence (CI 0.50 to 0.75) indicated the need for further deliberation; and low convergence (CI < 0.50 after repeated rounds) signalled unresolved disagreement, and such interventions were referred for consultation with the section chiefs of the relevant DoHS divisions and centres, as members of the thematic groups under the TWC, followed by further deliberation.

The approach draws on Amartya Sen's distinction between choice and preference:[50] choice reflects the option selected, while preference reflects the reasoning, value judgements, social priorities and contextual realities that underlie it. Participants in the buffer zone deliberation were not choosing for their own benefit but judging what is right for the population in terms of equity, policy relevance, social impact and feasibility. The approach recognizes that policy decisions reflect context specific values rather than the inherent superiority of particular interventions, and that preferences may shift across situations, such as between public health crises and periods of fiscal constraint. The convergence index made the value judgements, social priorities and contextual considerations underlying each decision explicit, allowing them to be examined and revised through deliberation.

Final selection of clinical interventions

The final selection applied the final cost effectiveness estimates, based on locally estimated unit costs, to the 224 clinical pathways, which were grouped into four streams (Table 10).

Table 10: Streams for the final selection of clinical interventions

Stream	Pathways	Route to the package
A	Linked to FairChoices interventions with a modelled health gain costing less than 0.5 times GDP per capita per healthy life year gained	Included
B	Linked to FairChoices interventions for which no health gain is modelled, mainly family planning	Included
C	Linked to FairChoices interventions with a modelled health gain costing 0.5 times GDP per capita or more per healthy life year gained	Placed in priority groups through consensus, on budget impact and the qualitative criteria
D	No FairChoices counterpart, together with the screening and referral of breast cancer	Placed in priority groups through consensus, on budget impact and the qualitative criteria

Note: Pathways linked to several FairChoices interventions take the stream of their best ranked linked intervention. GDP per capita: US$1,447.7 (2024).

Pathways in stream A were included, using 0.5 times GDP per capita per healthy life year gained as the threshold for inclusion. This is half the reference point used in the earlier deliberations and closer to recent estimates of the health that the same resources would produce elsewhere in the health systems of low and middle income countries, which generally fall well below one times GDP per capita.[51,52] For partial matches, whose ratios are optimistic because the Nepal pathway delivers only part of

the care modelled (Section 4.2.3), inclusion assumes that referral leads to timely treatment at higher levels. Pathways in stream B were included because they serve established programme commitments, such as family planning, polio immunization and safe abortion services, and their effects are not counted as health gains in FairChoices. The screening and referral of breast cancer is also linked to a FairChoices intervention without a modelled health gain, but it was considered with stream D because its budget impact is large compared with the other pathways in stream B.

Pathways in streams C and D were considered on their budget impact together with the four qualitative criteria of equity, policy relevance, social impact and feasibility. For stream C, the HAAD and the equity rank were also taken into account as measures of disease severity. The outcomes of the provincial and federal deliberations were the starting point. Taken together, they showed which services were judged feasible at the level of basic health services and which were better reached through the referral system, and the reasons recorded through the convergence index made explicit the value judgements behind choices on interventions close to the cutoff. Because these outcomes rested on the preliminary estimates, they informed the final selection as a whole rather than settling the decision on any single intervention.

A proposal was then prepared for streams C and D. It placed their pathways into priority groups and set out, for each pathway, whether it should be included, included with conditions (such as phased scale up, a specific delivery platform or delivery limited to screening and referral) or deferred to a later round. Pathways in streams A and B that the provincial deliberations had flagged were reviewed in the same way, so that conditions could be attached to them where needed. The proposal was discussed in consensus meetings with national level stakeholders, including MoHFS officials, representatives of divisions and centres under the DoHS, thematic experts and HDPs, and the priority groups were agreed through consensus. The cumulative cost of streams A and B and of each successive priority group was then set against the projected budget envelope (see Budget impact analysis above), so that the size of the final package could be decided at validation (Section 3.5.4).

Prioritization of Health Promotion and Ayurveda and Alternative Medicine interventions

Health Promotion and Ayurveda and Alternative Medicine interventions were prioritized separately from clinical interventions, largely through qualitative methods, using the criteria described in Section 3.5.2. Both categories were also presented as a separate group during the provincial deliberation workshops.

Health Promotion interventions were reviewed through a series of structured consultations and deliberations with officials from NHEICC, together with health promotion experts and other relevant stakeholders, including representatives of HDPs.

To complement these deliberations in the absence of data on effectiveness, population in need and costs, the 36 Health Promotion interventions were assessed through a structured multicriteria approach.[53,54] They were grouped into ten themes according to the main risk factor, condition or setting they address, and each theme was linked to the GBD 2023 causes it could influence, measured as DALYs

attributable to modelled risk factors or, where exposures are not modelled, total DALYs.[19,21] Each theme was scored from 1 to 3 on five criteria that operationalize those in Section 3.5.2: preventive value, from the linked burden; evidence of effectiveness and value for money, with WHO best buys scoring highest;[55] equity and positive externalities; policy relevance and feasibility; and fiscal implication, with revenue raising or very low cost measures scoring highest. The criteria were weighted 30%, 30%, 15%, 15% and 10%, respectively. A weighted score of 2.50 or more placed a theme in the first priority tier, 2.00 to 2.49 in the second and below 2.00 in the third. The assessment was reviewed with experts and senior officials during the consultations, and the intervention level results are presented in Annex 5.

Ayurveda and Alternative Medicine interventions were prioritized through a series of consultations and deliberations with experts and stakeholders. For interventions under Ayurveda and Alternative Medicine, officials from the Department of Ayurveda and Alternative Medicine and the Homeopathy Hospital, together with experts and stakeholders from outside these institutions, were consulted on each subcluster.

3.5.4 Validation of results

The results of the prioritization exercise were validated in stages. The unit cost estimates underpinning the analysis were first reviewed and validated in a dedicated workshop involving the Curative Service Division of the DoHS, and the inputs to the final run of the costing model and of FairChoices were reviewed with the programme divisions before the run was completed on 1 November 2026.

The final list of priority interventions, together with the associated budget impact estimates and the cumulative cost of streams A and B and of each successive priority group set against the projected budget envelope, was then reviewed at a national validation meeting held on 2 November 2026. Participants included section chiefs of the relevant sections within DoHS divisions and centres; directors of these divisions and centres, including NHEICC; officials from the Department of Ayurveda and Alternative Medicine; representatives of key HDPs working directly with these divisions and centres; and members of the TWC and Steering Committee. The meeting confirmed the approach and the alignment of the prioritized interventions with programme priorities and implementation realities. It also agreed a number of adjustments, which were incorporated into the final list on 4 November 2026 (Section 4.3.3).

The validated list was then reviewed by the TWC and endorsed by the Steering Committee. In doing so, the Steering Committee considered how far beyond the envelope projected under current allocation patterns it would be prepared to go and indicated a margin of 5% above the central projection as an indicative level rather than a commitment. On this basis the clinical interventions were organized into three groups: a recommended priority package, interventions that could be included as additional budget becomes available, and interventions deferred for now (Section 4.3.3). This report was also reviewed by senior officials of the MoHFS and DoHS, who are members of the TWC and Steering Committee, and by external reviewers, and their feedback has been incorporated.

4

Prioritized Interventions For The Basic Health Services Package

4 Prioritized Interventions For The Basic Health Services Package

This chapter presents the results of the priority setting process described in Chapter 3, in the same sequence. It sets out how the candidate interventions were narrowed to the final package, the unit costs and cost effectiveness of interventions, the outcomes of the deliberations and of the national validation, the interventions retained in each category and their delivery platforms, and the associated costs and budget impact. The implications for financing the package are discussed in Chapter 5.

The clinical results draw on the final run of the costing and cost effectiveness models, completed on 1 November 2026 after the inputs had been reviewed with the programme divisions. Three units are used, and each table states which one applies. Unit costs and budget impact are reported for the 224 care pathways in which the 204 clinical interventions were costed; cost effectiveness is reported by Nepal intervention, using the modelled intervention to which each was linked; and the package itself is described in pathways and, where useful, in Nepal interventions. Unless stated otherwise, costs are in Nepalese rupees (NPR) at 2025 prices, and cost effectiveness ratios are in US dollars at 2024 prices, the price base of the cost effectiveness analysis.

4.1 From candidate interventions to the final package

The exercise began with the 300 candidate interventions described in Section 3.3.3: 204 clinical interventions, 60 Ayurveda and Alternative Medicine interventions and 36 Health Promotion interventions (Table 6). Figure 15 traces how these interventions moved through the analysis. The three categories followed different routes, because the evidence that could be brought to bear on each of them differed.

The 204 clinical interventions were costed as 224 pathways, and every pathway was compared with the interventions in the FairChoices database. Cost effectiveness could be estimated for 81 interventions (92 pathways): 71 pathways matched fully and 21 in part, where basic health services deliver only part of the modelled care, such as screening and referral rather than treatment. A further 16 interventions, mostly for family planning, were linked to interventions in which no health gain is modelled, and the remaining 107 interventions (116 pathways) had no modelled counterpart. Every one of the 224 pathways has a unit cost and an estimate of budget impact, so the resource requirement could be estimated for the whole candidate list even where cost effectiveness could not.

Of the 81 interventions with a cost per healthy life year gained, 68 cost less than half of GDP per capita, and 13 half of GDP per capita or more (Section 4.2.3). On this basis the 224 pathways were grouped into the four streams described in Section 3.5.3 (Table 15). Stream A has 79 pathways linked to interventions below half of GDP per capita, and stream B has 15 pathways linked to interventions without a modelled health gain, mainly family planning. Stream C has 13 pathways linked to interventions at or above half of GDP per capita, and stream D has 117 pathways with no modelled counterpart, together with breast cancer screening. Streams A and B were included by rule. Streams C and D were placed into priority groups by consensus, on their budget impact

and the qualitative criteria, and the proposal was reviewed at the national validation meeting (Section 4.3.3).

The final clinical package has three groups (Table 16). Group 1, the recommended priority package, has 131 pathways: all of streams A and B, except the management of wounds and suturing, together with 38 pathways from streams C and D. Group 2 has 82 pathways that could be included as additional budget becomes available, and Group 3 has 11 pathways deferred for now. No pathway was excluded.

The cost of each group is compared with the projected budget envelope in Section 4.6.2. Health Promotion and Ayurveda and Alternative Medicine interventions followed a separate, largely qualitative route, and all 36 Health Promotion and all 60 Ayurveda and Alternative Medicine interventions were retained (Section 4.4). Together with the clinical interventions in Group 1, they form the revised package.

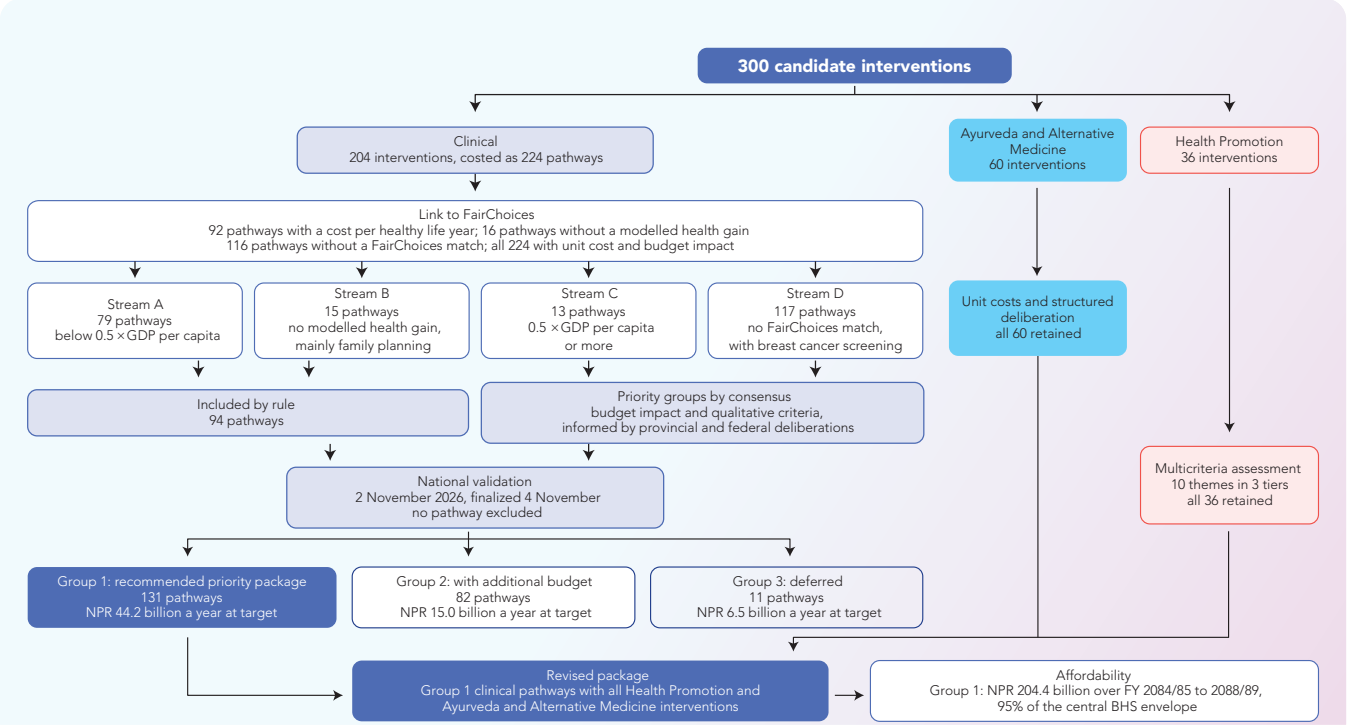


Figure 15: From candidate interventions to the final package

4.2 Unit costs and cost effectiveness

4.2.1 Evidence available by category

The amount of evidence that could be assembled differed markedly between the three categories and, within the clinical category, between pathways (Table 11). For the 92 clinical pathways linked to FairChoices interventions with modelled health gains, the analysis produced a unit cost, an estimate of budget impact and a cost per healthy life year gained. Together these pathways account for NPR 37.9 billion, or 58%, of the annual cost of the candidate list at target coverage. For the 16 pathways linked to FairChoices interventions without a modelled health gain, and for the 116 pathways without a FairChoices counterpart, for which no health gain could be documented in this round,

unit costs and budget impact were estimated, but cost effectiveness was not. These 132 pathways account for the remaining 42% of the cost.

Pathways without a cost effectiveness estimate are not necessarily of lower value. Most of the 116 pathways without a FairChoices counterpart are services that FairChoices does not model separately: vaccine doses given at birth or as boosters, such as the birth doses of hepatitis B and oral polio vaccine; first aid, stabilization and referral in emergencies; and the management of common conditions such as skin infections, low back pain, animal bites and nosebleeds. Nearly two fifths of them (45) are in the Communicable Diseases cluster, and 25 each are in RMNCAH-N and in Noncommunicable Diseases and Disability. These pathways were judged on the qualitative criteria together with their budget impact (Section 3.5.3). Ayurveda and Alternative Medicine interventions have unit costs but no estimates of the population in need, coverage or effectiveness, and Health Promotion interventions were assessed qualitatively without costing (Section 4.4).

Table 11: Evidence available for the candidate interventions, by category and evidence group

Category and evidence group	Number	Fair Choices interventions	Estimates available	Annual cost at target (NPR million)	Share of clinical cost (%)
Clinical: full match to FairChoices	71	59	Unit cost, budget impact, cost per HLY	31,609	48.1
Clinical: partial match	21	23	Unit cost, budget impact, cost per HLY (optimistic)	6,255	9.5
Clinical: matched, no health gain modelled	16	11	Unit cost, budget impact	2,382	3.6
Clinical: no FairChoices match	116	–	Unit cost, budget impact	25,526	38.8
Clinical, total	224	93		65,772	100.0
Ayurveda and Alternative Medicine	60	–	Unit cost	Not estimated	–
Health Promotion	36	–	Qualitative assessment (tiers)	Not costed	–

Note: Clinical interventions are counted as the 224 pathways in which the 204 interventions were costed; Ayurveda and Alternative Medicine and Health Promotion as interventions. FairChoices analysed 94 interventions; one, other modern methods of contraception, has no population in need in FairChoices and no linked pathway. In a partial match, basic health services deliver part of the care modelled in FairChoices, while FairChoices credits the health gain of the full treatment, so the ratio is optimistic. Two of the FairChoices interventions without a modelled health gain, breast and colorectal cancer screening, are also matched only in part, so 25 FairChoices interventions in all are partial matches. Annual cost at target is the population in need multiplied by target coverage and unit cost, at 2025 prices, including a 10% overhead on health worker time and a 5% contingency on other inputs. HLY: healthy life year.

4.2.2 Unit costs of interventions

Unit costs vary widely, reflecting the very different resources needed for a dose of vaccine and for a course of treatment for drug resistant tuberculosis (Table 12). The median pathway costs NPR 977 per case or, for chronic conditions, per person per year, and 115 of the 224 pathways

cost less than NPR 1,000. Vaccines are the least expensive, at NPR 130 to 1,974 per child, with pneumococcal vaccination the costliest of them. At the other end, 13 pathways cost more than NPR 10,000, driven by long courses of medicines or by admission. Treatment of extensively drug resistant tuberculosis in adults costs about NPR 686,000 per case and pre extensively drug resistant tuberculosis about NPR 519,000. These are followed by other regimens for tuberculosis, the initial management of bipolar disorder (NPR 28,276), the screening and management of sickle cell disease and thalassaemia (NPR 10,742) and the management of complications of abortion (NPR 10,526).

Unit costs alone say little about budget impact, which also depends on how many people need a service and how many of them are to be reached. Essential antenatal care has a moderate unit cost of NPR 5,804 per pregnancy, costed at eight contacts, but with about 694,000 pregnancies a year and a target coverage of 95%, it is the largest single item in the candidate list, at NPR 3.8 billion a year at target. The ten largest pathways, led by antenatal care, the longitudinal management of type 2 diabetes, primary trauma care, the management of low back pain and dental care, account for NPR 19.5 billion, or 30%, of the annual cost at target (Section 4.6.1). The unit cost, population in need, coverage and cost at target of every pathway are listed in Annex 3.

Table 12: Unit costs of clinical pathways by cluster (NPR per case, 2025 prices)

Cluster	Pathways	Minimum	Median	Maximum	Three costliest pathways (unit cost, NPR)	Annual cost at target (NPR million)
Immunization Services	12	130	359	1,974	Pneumococcal vaccination (1,974); Rotavirus vaccination (937); HPV immunization (930)	4,758
RMNCAH-N	60	7	838	10,526	Management of complications of abortion (10,526); Management of acute malnutrition in children under 5 (9,520); Surgical abortion (6,459)	16,389
Communicable Diseases	72	175	791	685,855	Extensively drug resistant TB, adults (685,855); Pre extensively drug resistant TB, adults (519,111); Extensively drug resistant TB, children (194,330)	13,186

Cluster	Pathways	Minimum	Median	Maximum	Three costliest pathways (unit cost, NPR)	Annual cost at target (NPR million)
NCDs and Disability	49	220	1,217	10,742	Screening and management of sickle cell disease and thalassaemia (10,742); Self care and participation, including bowel and bladder care (9,871); Type 1 diabetes, longitudinal management (9,566)	22,609
Mental Health Services	12	330	2,722	28,276	Initial management of bipolar disorder (28,276); Basic management of epilepsy (7,437); Initial management of psychotic disorders (4,214)	4,048
General Emergency Services	19	316	1,485	4,720	Primary management of common poisoning (4,720); Primary trauma care (3,785); Management of shock (3,031)	4,783
All clinical pathways	224	7	977	685,855		65,772

Note: Unit cost per case, per course of treatment or, for chronic conditions, per person per year, valued from the standard recipe of each pathway with 10% wastage on medicines and consumables, at 2025 prices, with a 10% overhead on health worker time and a 5% contingency on other inputs; equipment and referral costs are not included (Section 3.4.2). The minimum in RMNCAH-N is the annual cost per user of an intrauterine contraceptive device, whose insertion cost is spread over ten years. The full list is given in Annex 3.

Unit costs for the 60 Ayurveda and Alternative Medicine interventions were estimated with the same ingredient based approach, with inputs and prices based on the judgement of practitioners in Nepal (Section 3.4.2). Examples include the management of gouty and rheumatoid arthritis with Ayurveda, at about NPR 2,045 per case; shirodhara for anxiety, insomnia and related conditions, at about NPR 2,465; and naturopathy for chronic gastrointestinal disorders, at about NPR 3,115. Because the population in need and targets have not been set for these interventions, their unit costs are not included in the budget impact (Section 4.6).

4.2.3 Ranking of clinical interventions by cost per healthy life year gained

For the 81 clinical interventions with a modelled health gain, the healthy life years gained by scaling up from current coverage to target over five years were estimated in FairChoices,

using its effect sizes and population model together with the Nepal unit costs and coverage (Section 3.4.5). Across the 82 modelled interventions with a health gain, scale up would gain about 1.82 million healthy life years for an incremental cost of US$325 million over five years, an average of about US$178 per healthy life year. Figure 16 ranks the 53 Nepal interventions with a full match. The 23 partial matches are listed separately in Table 14, and the full league table, by Nepal intervention, is given in Annex 6.

What stands out is how many of these interventions are highly cost effective. The 68 interventions that cost less than half of GDP per capita (US$724) per healthy life year gained deliver 95% of the healthy life years for 47% of the incremental cost, about US$89 per healthy life year, against about US$1,831 for the other 14. Of the 53 Nepal interventions with a full match, 44 cost less than half of GDP per capita and 9 half of GDP per capita or more. The most cost effective are the treatment of acute infections and the core childhood vaccines: the treatment of trachoma, typhoid, measles, and neonatal sepsis and pneumonia, together with pentavalent, measles rubella and pneumococcal vaccination, all cost less than US$70 per healthy life year gained. Most of these are inexpensive services that avert deaths or long illness, many of them early in life, when each death averted saves many years of healthy life.

At the other end, nine full matches cost half of GDP per capita or more per healthy life year gained: the management of complications of abortion (US$4,490), essential antenatal care (US$3,758), the management of anxiety disorders (US$2,906), the treatment of acute pharyngitis in children (US$2,265), the treatment of extensively drug resistant tuberculosis (US$1,923), the basic management of migraine (US$1,703), the longitudinal management of asthma (US$1,593), the initial management of bipolar disorder (US$1,152) and the management of urinary tract infection (US$1,027). The syndromic management of sexually transmitted infections falls below the line once its four linked conditions are pooled (US$227), although its links to chlamydia (US$5,096) and trichomoniasis (US$2,770) lie above it. A high ratio should not be read as a judgement that a service has little value. For antenatal care, the Nepal pathway costs the full set of contacts and tests, whereas the model credits it only with the health gains that it attributes directly to antenatal care. Calcium supplementation is the largest single input in the Nepal pathway, but FairChoices models its effect as a separate intervention; without calcium, the ratio would be US$1,963, or 1.36 times GDP per capita.

Three ratios are lower than they would otherwise be because a component of the FairChoices intervention was given no Nepal cost while its health gain was kept, so they are optimistic. The ratio for type 2 diabetes, US$711 or 0.49 times GDP per capita, excludes insulin dependent care, which is not part of the Nepal pathway; the ratio for sickle cell disease and thalassaemia, US$618, takes only the visit and test costs of newborn screening; and the ratio for trachoma excludes epilation. Several of the services with high ratios are long established in the BHSP and tied to national commitments, so their place in the package was decided on the qualitative criteria and existing commitments rather than on the ratio alone (Section 4.3).



Figure 16: Cost per healthy life year gained for Nepal interventions with a full match (US$, 2024 prices, log scale)

Note: Each bar is one FairChoices intervention, labelled with the corresponding Nepal intervention. Bands relative to GDP per capita of US$1,447.7 in 2024. Ratios are not weighted for disease severity.

Grouped by pathway, 61 of the 71 fully matched pathways fall below half of GDP per capita and 10 at or above it (Table 13). Communicable Diseases and RMNCAH-N have the largest numbers of highly cost effective pathways, while most of the pathways in Noncommunicable Diseases and Disability and in General Emergency Services either match FairChoices only in part or have no FairChoices counterpart.

Table 13: Clinical pathways by cluster and cost effectiveness band (number of pathways)

Cluster	Full match: below 0.5 × GDP pc	Full match: 0.5 × GDP pc or more	Partial match	No health gain modelled	No FairChoices match	Total
Immunization Services	6	0	0	1	5	12
RMNCAH-N	18	3	2	12	25	60
Communicable Diseases	19	3	4	1	45	72
NCDs and Disability	11	1	10	2	25	49
Mental Health Services	6	3	2	0	1	12
General Emergency Services	1	0	3	0	15	19
Total	61	10	21	16	116	224

Note: Pathways linked to several FairChoices interventions take the band of their best ranked linked intervention; for all six such pathways, a pooled ratio (the sum of incremental costs divided by the sum of healthy life years gained) gives the same band, below 0.5 times GDP per capita. Where one FairChoices intervention covers several pathways, each pathway takes the band of that intervention. GDP pc: GDP per capita (US$1,447.7, 2024).

The 23 partial matches need particular care (Table 14). In these cases the Nepal pathway delivers only part of the care modelled in FairChoices, for example screening and referral for oral cancer, cataract or acute kidney injury, while FairChoices credits the health gain of full treatment. Their ratios are therefore optimistic, which is why several of them, such as the diagnosis and referral of visceral leishmaniasis and the screening and referral of oral cancer, appear at the very top of the ranking. Twenty of the 23 fall below half of GDP per capita. Their real value depends on whether referral leads to timely and affordable treatment at higher levels, which was taken into account in the conditions attached to some of them (Section 4.3.3).

Table 14: Nepal interventions that deliver part of a modelled intervention

Rank	Nepal intervention (part delivered through BHS)	Modelled intervention (FairChoices)	US$ per HLY	× GDP per capita
2	Diagnosis and referral of visceral leishmaniasis	Treatment of Leishmaniasis	0.5	<0.01
3	Screening and referral of oral cancer	Treatment of oral cancer	0.5	<0.01
4	Primary management of burns	Management of burns	0.6	<0.01
7	Identification and referral of acute kidney injury	Management of acute kidney disease	1.1	<0.01
9	Management of hydatidosis (echinococcosis)	Treatment of Echinococcosis	3.1	<0.01
10	Identification and referral of cataract	Treatment of cataract	6.1	<0.01

Rank	Nepal intervention (part delivered through BHS)	Modelled intervention (FairChoices)	US$ per HLY	× GDP per capita
12	Emergency management and referral of ischaemic heart disease	Secondary prevention of ischemic heart disease	11	0.01
13	Referral of acute kidney injury (kidney failure)	End stage kidney failure, hemodialysis	14	0.01
20	Basic respiratory rehabilitation	Exercise-based pulmonary rehabilitation of COPD	33	0.02
25	Initial management and referral of gastrointestinal bleeding	Management of gastrointestinal bleeding	54	0.04
36	Postpartum haemorrhage, first aid and referral	Management of postpartum hemorrhage	104	0.07
37	Emergency management and referral of stroke	Secondary prevention of stroke	107	0.07
40	Basic cardiovascular rehabilitation	Exercise based cardiac rehabilitation	122	0.08
44	Tobacco cessation counselling	Tobacco cessation counseling (including nicotine agonist treatment)	198	0.14
46	Basic physiotherapy after stroke	Rehabilitation of stroke	211	0.15
48	Community home based care for PLHIV	Management of HIV	233	0.16
55	Primary trauma care (upper limb fractures)	Management of upper extremity fractures	314	0.22
59	Referral of child and adolescent mental disorders	Management of attention disorders	335	0.23
65	Primary management of common poisoning	Intoxication management	505	0.35
67	Screening and management of sickle cell disease and thalassaemia	Sickle cell screening and management	618	0.43
69	Management of substance use disorder	Opioid Agonist Treatment (OAT) and psychosocial support	846	0.58
72	Screening of hepatitis C for PWID	Treatment of hepatitis C	1,185	0.82
79	First line support and referral for GBV survivors	Post gender-based violence care	3,088	2.13

Note: Rank among the 82 FairChoices interventions with a modelled health gain. In a partial match, Nepal costs and coverage are used for the part delivered through basic health services, while FairChoices credits the health gain of the full treatment, so the ratio is optimistic. HLY: healthy life year; PLHIV: people living with HIV; PWID: people who inject drugs.

Disease severity is reflected in the results through the health adjusted age at death (HAAD), which FairChoices reports for each intervention with a modelled health gain (Section 3.5.2). A lower HAAD means that the condition causes greater lifetime health loss, usually because it strikes early in life. HAAD ranges from about 5 years for measles rubella vaccination and 12 years for pentavalent vaccination to more than 70 years for cataract treatment and dementia care, with a median of about 66 years. FairChoices also reports an equity rank that gives more weight to health gains for people with a lower HAAD.

Taking severity into account in this way changes the order only modestly:

77 of the 82 interventions move by no more than three places. Measles rubella vaccination (from 21st to 14th), HPV immunization (26th to 21st) and the screening and treatment of cervical precancer (32nd to 27th) move up the most, while the primary prevention of cardiovascular disease (22nd to 26th) , basic physiotherapy for neurological conditions (46th to 50th) and the basic management of dementia (60th to 63rd) move down.

For the 16 pathways linked to FairChoices interventions without a modelled health gain, the benefits operate largely through fertility and are not counted as healthy life years in the model. Most are family planning services, from condoms and pills to implants, intrauterine devices and sterilization, together with medical and surgical abortion; polio vaccination, tuberculosis preventive therapy, primary palliative care and screening for breast and colorectal cancer also fall in this group. These services are central to existing programmes and to national commitments. Fifteen of them form stream B and were included as programme commitments; breast cancer screening, which has a sizeable budget impact, was considered with stream D (Section 4.3.2).

4.3 Outcomes of deliberation

4.3.1 Provincial deliberations

The provincial deliberations in Karnali, Sudurpashchim and Lumbini provinces (Section 3.5.3) focused on the feasibility of delivering candidate interventions at the provincial and local levels, drawing on the preliminary cost effectiveness estimates available at the time. Their main contribution was to identify which interventions participants judged feasible within current or near term capacity, which they judged not feasible, and the conditions under which feasibility could be improved. A comparative summary of findings by thematic area is provided in Annex 4 (Table 39).

Across the three provinces, participants broadly agreed that most promotive, preventive and primary care services, such as antenatal and postnatal care, immunization, family planning and the management of common infectious diseases, were feasible within current or near term provincial capacity.

In contrast, several interventions were judged not feasible for delivery through BHS platforms, mainly because of shortages of human resources for health and gaps in physical infrastructure. All three provinces flagged advanced cancer management, specialized cardiac care (such as management of acute coronary syndrome, cardiac stenting and cardiac surgery) and specialized mental health care (such as inpatient care and management of advanced dementia). Two of the three provinces also flagged palliative care, specialized paediatric surgical care (for example, club foot correction, hydrocephalus shunting and management of Wilms tumour), burn management, and stroke care from acute treatment to rehabilitation; neurosurgery was flagged in Lumbini. For most of these interventions, participants recommended strengthening referral pathways to higher level facilities rather than delivery at the BHS level. Some interventions were judged partially feasible: in Sudurpashchim, cervical cancer screening with thermocoagulation was considered feasible, while advanced management was not; in Lumbini, dental services were considered extendable below the district level through dental hygienists.

The deliberations also highlighted province specific considerations. Participants in Karnali identified

governance instability, including the discontinuation of health programmes across successive administrations, as a barrier to feasibility distinct from human resources or infrastructure. Participants in Sudurpashchim noted that the province's dispersed population and difficult terrain call for differentiated approaches. They also noted that the time window for treating acute cardiac conditions is often exceeded before patients reach a tertiary facility, so referral alone is insufficient without prehospital stabilization; and they pointed to stigma and other demand side barriers to mental health services. Participants in Lumbini linked the feasibility of NCD prevention to fiscal and legislative measures, such as taxes on sugar and sodium, and raised concerns about workforce sustainability where key programmes rely on temporary staff. Proposed mitigation strategies included task shifting (Sudurpashchim), tiered, platform specific delivery of chronic care, and the development of standard treatment protocols for services such as burn management (Lumbini).

Overall, the provincial deliberations indicated that what is feasible at the BHS level is not fixed and can be expanded progressively through investment in human resources for health, task shifting, tiered service delivery and stronger referral systems. These findings were carried forward to the final selection and the national validation, where they informed the priority groups and the conditions attached to many pathways (Section 4.3.3). They also helped to refine the candidate list, particularly by flagging interventions that were not appropriate for delivery as part of BHS. Because the deliberations covered three of the seven provinces with purposively selected participants, these findings indicate the main feasibility constraints rather than a nationally representative assessment (Section 8.2).

4.3.2 Federal deliberations and final selection

The federal deliberations were held on the preliminary estimates of the time, which used the default unit costs in FairChoices (Section 3.5.3). They applied the rule described in Section 3.5.3: interventions with a cost effectiveness estimate were ranked against a cutoff of one times GDP per capita, with a buffer zone covering the 15% of ranked interventions on either side, and the interventions in the buffer zone were deliberated on equity, policy relevance, social impact and feasibility with the support of the convergence index. The pathways without a cost effectiveness estimate were deliberated against the same criteria, together with their budget impact. Several services in or near the buffer zone were recognized as core components of existing programmes, among them safe delivery, the management of acute malnutrition, antenatal care, diabetes care and the treatment of drug resistant tuberculosis. For such services, participants saw the decision as one about the conditions of delivery, such as the platform, the target or the pace of scale up, rather than about inclusion as such.

With the final estimates, based on local unit costs, the ratios and the ranking changed, and the outcomes of these rounds were carried forward as an input rather than applied to the new ranking. The clinical pathways were grouped into the four streams described in Section 3.5.3 (Table 15). Streams A and B, 94 pathways costing NPR 31.6 billion a year at target, were included by rule. Every pathway included by rule on the basis of its ratio therefore costs less than half of GDP per capita per healthy life year gained; the highest in stream

A, for the longitudinal management of type 2 diabetes, is US$711, about 0.49 times. Stream B has no ratio and was included under a separate rule, because its pathways serve established programme commitments, mainly family planning. Streams C and D, 130 pathways costing NPR 34.2 billion, were placed into priority groups by consensus, on their budget impact and the qualitative criteria, starting from the provincial and federal findings.

Table 15: Clinical pathways by stream (final estimates)

Stream	Rule	FairChoices interventions	Pathways	Current cost (NPR million)	Annual cost at target (NPR million)	Share (%)	Total 2027 to 2031, nominal (NPR million)	Route
A	Health gain, below 0.5 × GDP pc	68	79	10,507	29,742	45.2	136,599	Included
B	No modelled health gain (mainly family planning)	10	15	1,069	1,870	2.8	9,535	Included
C	Health gain, 0.5 × GDP pc or more	14	13	1,877	8,122	12.3	35,003	Priority groups by consensus
D	No FairChoices match, plus breast cancer screening	1	117	8,963	26,039	39.6	119,045	Priority groups by consensus
Total		93	224	22,416	65,772	100.0	300,183	

Note: GDP pc: GDP per capita (US$1,447.7, 2024). FairChoices interventions are counted by their own band. Pathways linked to several FairChoices interventions take the stream of their best ranked linked intervention, so the syndromic management of sexually transmitted infections falls in stream A, although its links to the treatment of chlamydia and trichomoniasis are above half of GDP per capita. Breast cancer screening is linked to a FairChoices intervention without a modelled health gain but was considered with stream D because of its budget impact. Current costs and five year totals are summed across pathways; they differ from the model estimates in Table 21 by about 0.1% for current cost and less than 0.1% over five years, while costs at target are identical.

4.3.3 National validation and the final package

The proposed priority groups for streams C and D, together with the conditions proposed for selected pathways in streams A and B, were reviewed at the national validation meeting on 2 November 2026 and finalized on 4 November. The meeting confirmed the approach and made several changes. No pathway was excluded: biannual vitamin A distribution and preventive chemotherapy for soil transmitted helminths, which had been proposed for exclusion, were included with conditions, as a blanket approach now to be tailored to need over time. The initial management of bipolar disorder was deferred rather than excluded. Five pathways moved from deferral into Group 2: the basic management of migraine, the longitudinal management of asthma, the management of acute pharyngitis in adults, basic assistive

products for mobility, and the screening and referral of congenital heart disease. The management of skin infections moved into Group 1. The management of wounds and suturing, although in stream A, was recognized as covered within primary trauma care; it is listed in Group 3 and its cost is not counted separately.

The final clinical package is therefore set out in three groups (Table 16). Group 1, the recommended priority package, contains all 93 counted pathways in streams A and B together with the 38 pathways in streams C and D placed in the first priority group, which are mainly maternal, newborn and child health services, communicable disease care and immunization. Five of these have ratios at or above half of GDP per capita: essential antenatal care, care for survivors of gender based violence, hepatitis C screening for people who inject drugs, the treatment of acute pharyngitis in children and the treatment of extensively drug resistant tuberculosis in adults. They were placed in Group 1 because they are programme commitments or were judged essential on the qualitative criteria. Group 2 contains the 82 pathways in streams C and D placed in the second and third priority groups, which could be included with additional budget; most of them are for noncommunicable diseases, communicable diseases and general emergencies. Group 3 contains 11 pathways deferred for now, to be included only if additional budget is secured. Table 17 shows how the groups are made up by cluster.

Table 16: Final clinical package by group

Group	Pathways (by stream)	Current cost (NPR million)	Annual cost at target (NPR million)	Share of candidate cost at target (%)	Total 2027 to 2031, nominal (NPR billion)
1: Recommended priority package	131 (A 78, B 15, C 5, D 33)	16,250	44,189	67.2	204.4
2: Include with additional budget	82 (C 7, D 75)	4,240	14,951	22.7	66.3
3: Deferred for now	11 (A 1, C 1, D 9)	1,797	6,456	9.8	28.5
Not counted: wounds and suturing, covered within primary trauma care	(1 pathway in Group 3)	129	177	0.3	1.0
All candidate pathways	224	22,416	65,772	100.0	300.2

Note: Group 3 has 11 pathways, but its costs exclude the management of wounds and suturing, which is shown separately. Current costs are summed across pathways and differ slightly from the model estimate in Table 21; costs at target are identical.

Table 17: Final clinical package by group and cluster (pathways; NPR billion a year at target)

Cluster	Group 1	Group 2	Group 3
RMNCAH-N	48; 14.4	11; 1.9	1; 0.1
Communicable Diseases	38; 9.7	33; 3.5	1; 0.02

Cluster	Group 1	Group 2	Group 3
NCDs and Disability	23; 11.8	21; 6.0	5; 4.8
Immunization Services	12; 4.8	–	–
Mental Health Services	7; 1.1	3; 1.7	2; 1.3
General Emergency Services	3; 2.4	14; 1.9	2; 0.4
Total	131; 44.2	82; 15.0	11; 6.5

Note: Each cell gives the number of pathways and their annual cost at target, at 2025 prices. Group 3 excludes the cost of the management of wounds and suturing.

In Groups 1 and 2, 25 pathways are included with conditions, and none of the conditions lowers target coverage, so they change how a service is delivered rather than what it costs. For the longitudinal management of type 2 diabetes, cardiovascular disease and chronic obstructive pulmonary disease, the condition is tiered, platform specific delivery of chronic care. For primary trauma care and the emergency management of ischaemic heart disease and stroke, it is triage, stabilization and referral that reaches care within the treatment window. Basic physiotherapy, the primary management of burns, the basic management of dementia, the initial management of post-traumatic stress disorder, the identification and referral of child and adolescent mental disorders, screening for oral and colorectal cancer, and primary palliative care are to be expanded in phases as capacity grows, in several cases once a standard treatment protocol and trained staff are in place. Cervical cancer screening is to be delivered at BHS level, with thermocoagulation, and more advanced management by referral, building on the model already used in Sudurpashchim.

The other conditions record a programme commitment or a legal basis, as for antenatal care, support for survivors of gender based violence, hepatitis C screening for people who inject drugs and the management of complications of abortion, or define the scope of a service, as for the basic management of anxiety disorders and urinary tract infection and the screening and referral of breast cancer and congenital heart disease. They also record the tailored approach to vitamin A and deworming. The full list of pathways by group, with their conditions, is given in Annex 3.

The 11 deferred pathways cost NPR 6.5 billion a year at target, and the management of low back pain, joint pain and periodontal disease accounts for 65% of it. Most were deferred because of their budget impact rather than their value, and several, such as low back pain and joint pain, are also addressed in part by the Ayurveda and Alternative Medicine package. They are candidates for the next round, as fiscal space and facility readiness allow.

4.4 Health promotion and Ayurveda and alternative medicine interventions

Health Promotion and Ayurveda and Alternative Medicine interventions were prioritized through the qualitative criteria and structured deliberations described in Section 3.5.3, without cost effectiveness modelling. Their results are therefore presented as the interventions retained in the package, grouped by theme and subcluster, rather than as estimates of cost per healthy life year. In line with the approach agreed for this round, their budget requirement is expressed as a

share of the corresponding allocation in the health budget (Section 3.4).

The terms prioritized and retained therefore mean different things for the three categories of interventions. For clinical pathways, placement in a priority group reflects cost effectiveness where it could be estimated, budget impact and the qualitative criteria, and the groups set the order in which pathways are financed and scaled up. For Health Promotion, retention means that the intervention stays in the package, and its tier signals the priority for protected funding; it rests on a structured assessment of burden, evidence, equity, policy relevance and fiscal implications rather than on modelled health gains. For Ayurveda and Alternative Medicine, retention reflects the recognition of these services in the PHSR and their existing provision through Ayurveda facilities; it is not a finding that each intervention is effective, and no tiers were set in this round (Section 4.4.2). Applying only the qualitative criteria to all categories would have discarded the evidence on value for money that is available for 92 clinical pathways, so cost effectiveness was used where it existed, and budget impact and the qualitative criteria where it did not (Section 3.5.3).

4.4.1 Health promotion

All 36 Health Promotion interventions in Cluster 8 were retained. Together they cover the full range of promotive action, from fiscal and regulatory advocacy, through mass media and community engagement, to services delivered in schools and other settings, and they fall into ten themes (Table 18). Sixteen interventions in three themes, namely tobacco and alcohol control, nutrition and food fortification, and NCD risk awareness, form the first priority tier, because they address the largest share of preventable burden and include several WHO best buys. Thirteen interventions in four themes form a second tier to be delivered on a targeted basis, in endemic districts, for key populations and through schools. The remaining seven form a third tier that is best delivered through FCHV, school and healthy palika platforms rather than through new budget lines. The intervention level matrix is given in Annex 5.

Table 18: Prioritized Health Promotion interventions by theme

Priority tier	Theme	No.	Main interventions
Tier 1: protect and scale	Tobacco and alcohol control	7	Advocacy for tobacco and alcohol taxes; antitobacco mass media; mCessation; group education for smokers; advocacy with political and local leaders; adolescent risk factor counselling
	Nutrition and food fortification	6	Fortification of salt, wheat flour and rice; nutrition awareness; advocacy on breastmilk substitutes regulation and child health
	NCD risk awareness and healthy ageing	3	Awareness of salt, sugar sweetened beverages, trans fat, hypertension and diabetes; NCD risk factor advocacy; senior citizen health awareness

Priority tier	Theme	No.	Main interventions
Tier 2: scale with targeting	Vector control and HIV prevention	3	Insecticide treated nets; indoor residual spraying; community HIV prevention and screening for key populations
	Communicable disease communication	3	Community engagement for dengue, malaria and other vector borne diseases; communication on 52 communicable diseases; advocacy
	WASH and environmental health	2	Hygiene and WASH messaging; advocacy on environmental health and antimicrobial resistance
	School health	5	School health education; periodic health screening; preventive oral health; curriculum review; basic care and referral
Tier 3: deliver through existing platforms	Outbreak risk communication	2	Risk communication and community engagement; media monitoring and social listening
	Injury, violence and GBV awareness	2	Awareness of road injuries, burns and acid attacks; community GBV prevention
	Settings based promotion and campaigns	3	Healthy palika, health promoting schools and hospitals; health days; organ transplantation awareness
Total		36	Tier 1: 16 interventions; Tier 2: 13; Tier 3: 7

Note: Tiers follow the structured assessment in Section 3.5.3 and Annex 5. FCHV: Female Community Health Volunteer; GBV: gender based violence; WASH: water, sanitation and hygiene.

Unit costs were not estimated for Health Promotion interventions in this round. Most are population wide activities, such as campaigns, advocacy and regulation, which have no standard unit of service, and no itemized costing inputs were available for Cluster 8. Their budget is therefore expressed as a share of the allocation for health promotion and preventive services, which averaged NPR 8.52 billion a year over FY 2080/81 to 2083/84 (9.4% of the health budget). Only about a fifth of this envelope can be traced to the Cluster 8 themes, and tobacco, alcohol and NCD risk measures together receive about 1.4% of it, which makes a protected allocation for the first tier the main budget priority for Health Promotion (Section 5.7).[28]

4.4.2 Ayurveda and alternative medicine

Sixty Ayurveda and Alternative Medicine interventions were retained across the four subclusters (Table 19). Ayurveda (including yoga) accounts for 23 interventions, naturopathy for 14, homeopathy for 12 and acupuncture, including acupressure and cupping, for 11. More than half (35) are delivered at Ayurvedic Aushadhalaya, the facilities that bring the Ayurveda system closest to communities. A further 19, including most acupuncture therapies and several Ayurveda and naturopathy services that need trained practitioners and dedicated space, require an Ayurveda Health Service Centre equivalent to a basic hospital, and six are offered through Nagarik Aarogya Kendra.

Table 19: Prioritized Ayurveda and Alternative Medicine interventions by subcluster and delivery platform

Subcluster	No.	Main conditions and services	Aushadhalaya	Ayurveda Health Service Centre	Nagarik Aarogya Kendra
Ayurveda (including yoga)	23	Common acute illnesses (influenza like illness, gastritis, urinary tract infection, sinusitis); women's health and lactation support; arthritis and chronic pain; classical therapies (shirodhara, nasya, swedana, abhyanga); rasayana; Swarna Bindu Prashan for children aged 1 to 5 years; yoga for health promotion, therapy and NCDs	12	5	6
Naturopathy	14	Complementary care for diabetes, hypertension, dyslipidaemia and obesity; spinal and joint conditions; digestive disorders; anxiety and depression; skin and headache disorders	7	7	0
Acupuncture (including acupressure and cupping)	11	Acupressure and cupping for low back pain, cervical spondylosis, osteoarthritis and frozen shoulder; acupuncture for stroke rehabilitation, facial palsy, neuralgia, neuropathy, migraine, sciatica, sleep disorders and dysmenorrhoea	4	7	0
Homeopathy	12	Arthritis and hyperuricaemia; respiratory, digestive, skin and urinary complaints; benign prostatic hypertrophy; complementary NCD care; women's health; delayed developmental milestones	12	0	0
Total	60		35	19	6

Note: Counts by delivery platform refer to the level of management recorded for each intervention. Ayurveda Health Service Centre: general Ayurveda hospital, equivalent to a basic hospital.

The package concentrates on long term and recurring conditions that drive much of Nepal's disability, and it builds on the long tradition of Ayurveda and allied systems within the country's pluralistic health system. Musculoskeletal and chronic pain conditions, including low back and neck pain, arthritis, spondylosis and frozen shoulder, appear in every subcluster; musculoskeletal disorders account for 6.7% of all DALYs in Nepal, and low back pain alone for 0.33 million DALYs.[19] Other recurring themes are digestive and urinary complaints, women's health (dysmenorrhoea, leucorrhoea, polycystic ovary syndrome and lactation support), stress, sleep and mild mental health problems, and child growth and development. In Ayurveda, yoga, naturopathy and homeopathy, the management of type 2 diabetes and hypertension is framed explicitly as complementary to standard care, and three Ayurveda interventions build referral into the service itself.

Unit costs for these interventions, estimated through an ingredient based approach that drew largely on the judgement of practitioners in Nepal, are reported in Section 4.2.2. Because evidence on effectiveness, coverage and the population in need was not available, cost effectiveness could not be estimated. Where trial evidence exists, it is modest: for chronic low back pain, yoga performs about as well as other forms of exercise, and acupuncture improves pain and function compared with no treatment but not clearly compared with sham treatment.[56,57] This supports positioning these services as complementary to modern medical care, with clear clinical procedures, referral links and outcome reporting through AHMIS, as set out in Section 6.3.2.

Allocations for Ayurveda and Alternative Medicine averaged NPR 1.33 billion a year over FY 2080/81 to 2083/84 (1.5% of the health budget) and grew by about 13% a year. The part delivered within BHS, mainly through local level Aushadhalaya and Nagarik Aarogya Kendra, more than doubled from NPR 0.19 billion to NPR 0.45 billion, yet remains around 1% of the BHS envelope (Section 5.7).[28]

4.5 Delivery platforms for the package

The delivery platforms follow the tiers of health institutions defined in the PHSR: (i) community, covering FCHVs, outreach clinics, schools and community health units; (ii) basic health service centre and equivalent, covering the former health posts, primary health care centres and urban health centres; and (iii) basic hospital (5, 10 or 15 beds), including the former PHCCs. Ayurveda and Alternative Medicine interventions use the Ayurvedic Aushadhalaya, the Ayurveda Health Service Centre equivalent to a basic hospital, and the Nagarik Aarogya Kendra.

Table 20 shows how the clinical interventions in the final package are distributed across these platforms. Of the 114 interventions in Group 1, 68 are delivered at basic health service centres, 30 at basic hospitals, 10 through community platforms together with basic health service centres, and 6, for drug resistant tuberculosis, at designated treatment centres. Because most of the package is delivered at basic health service centres and basic hospitals, this distribution also shows where the assessment of facility readiness for the revised package should concentrate (Section 6.3.3).

Table 20: Clinical interventions in the final package by cluster and delivery platform (number of interventions)

Cluster	Group 1 by delivery platform				Group 1	Groups 1 and 2	All candidates
	Community	BHS centre	Basic hospital	Other	Total	Total	Total
Immunization Services	1	11	0	0	12	12	12
RMNCAH-N	6	18	7	0	31	39	40
Communicable Diseases	3	24	5	6	38	71	72

Cluster	Group 1 by delivery platform				Group 1	Groups 1 and 2	All candidates
	Community	BHS centre	Basic hospital	Other	Total	Total	Total
NCDs and Disability	0	12	11	0	23	44	49
Mental Health Services	0	2	5	0	7	10	12
General Emergency Services	0	1	2	0	3	17	19
Total	10	68	30	6	114	193	204

Note: Platform at which the intervention is first delivered, as recorded in the candidate list. Community includes interventions delivered through schools, FCHVs or outreach together with basic health service centres. Other: treatment centres and subcentres for drug resistant tuberculosis. Interventions are counted once; bundled interventions are counted in the highest priority group of any of their components (Annex 3.1). Groups 1 and 2 by platform: community 12, BHS centre 118, basic hospital 57, other 6. The two drug susceptible TB interventions for adults (Annex 3, interventions 115 and 117) are counted at basic health service centres.

4.6 Costs and budget impact

4.6.1 Baseline and projected costs to 2031

At current coverage, the 224 candidate clinical pathways cost NPR 22.4 billion a year at 2025 prices, or about NPR 760 per person.[48] If every pathway reached its target coverage, the annual cost would rise to NPR 65.8 billion, about NPR 2,220 per person and nearly three times the current level (Table 21). Of this amount, NPR 22.4 billion (34%) maintains current coverage, NPR 12.5 billion (19%) expands the coverage of services that are already provided, and NPR 30.8 billion (47%) pays for additional services, such as tests, medicines and procedures that the pathways specify but that are not part of current BHS practice. The size of this last component shows that the candidate list goes well beyond extending the reach of current services: it also deepens what each service contains. For the recommended package, Group 1, the annual cost at target is NPR 44.2 billion, about NPR 1,490 per person, of which NPR 16.3 billion maintains current coverage.

Figure 17 places these components in the three dimensions of the UHC cube: who is covered, which services are covered and what proportion of the costs is covered.[1] Because basic health services are free at the point of use, the third dimension is fixed at 100% of direct costs, so the cube grows only in width and depth. Extending current services to people in need who do not yet receive them, the population dimension, accounts for NPR 12.5 billion, or 19% of the cost at target. The baseline and target coverage behind this dimension are given for each intervention in Annex 3. Widening the package, the services dimension, accounts for NPR 30.8 billion, or 47%: NPR 15.1 billion adds tests, medicines or contacts to 101 pathways that are already part of current practice, and NPR 15.7 billion covers 75 pathways whose recipe is not yet part of current BHS practice; most of them already reach some people, but their whole cost is counted as additional. Nearly half of the cost at target therefore comes from widening the package rather than from reaching more people, so the choice of services matters most

for affordability. With BHS free at the point of use, each service added to the package also shifts cost from households to the public budget. Within the scale up of Group 1, this suggests that extending services already provided to people not yet reached, which costs less and serves equity directly, could be given weight in the early years alongside the addition of new service content (Section 5.8). The projections in this chapter assume that both proceed at the same pace.

The projection assumes that the coverage of every pathway closes a fifth of the gap to its target each year from 2026, reaching the target in 2031, and that prices rise by 5% a year (Section 3.5.3). On this path, the annual cost of all candidate pathways rises from NPR 23.6 billion in 2026 to NPR 88.1 billion in 2031 in nominal terms (Figure 18). Over the five years 2027 to 2031, which correspond to FY 2084/85 to 2088/89, the total is NPR 300.2 billion in nominal terms, or NPR 242.2 billion at 2025 prices. Maintaining current coverage accounts for NPR 136.7 billion of the nominal total, expanding coverage for NPR 47.3 billion and additional services for NPR 116.2 billion. Group 1 follows the same path, from NPR 17.1 billion in 2026 to NPR 59.2 billion in 2031.

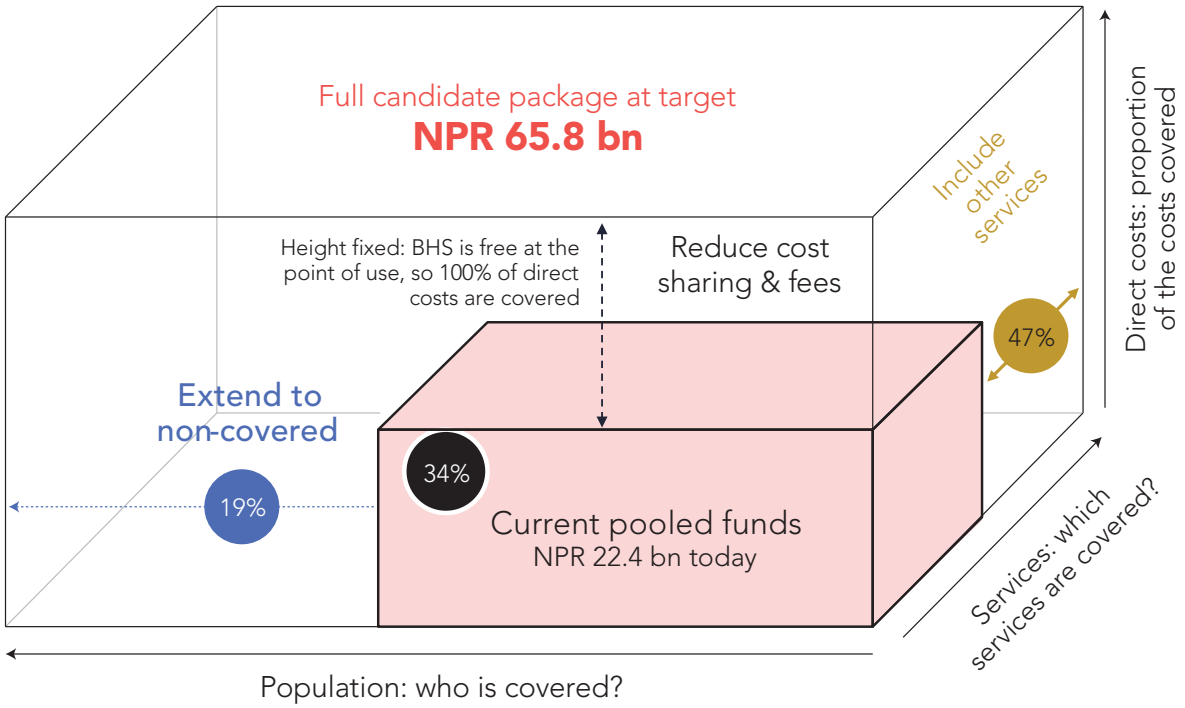


Figure 17: The UHC cube: what the full candidate package would buy

Note: Annual cost of the 224 candidate clinical pathways at target coverage, 2025 prices. The volume of each block is proportional to its cost. Source: costing of the candidate pathways (Section 3.4); cube adapted from the World Health Report 2010.[1]

Table 21: Annual cost of the candidate clinical pathways by component, 2026 to 2031 (NPR million)

Year	Fiscal year	Scale up to target (%)	Price index	Current coverage	Coverage expansion	Additional services	Total, nominal	Total, 2025 prices
2026	2083/84	0	1.050	23,560	0	0	23,560	22,440
2027	2084/85	20	1.103	24,740	2,770	6,790	34,300	31,110

Year	Fiscal year	Scale up to target (%)	Price index	Current coverage	Coverage expansion	Additional services	Total, nominal	Total, 2025 prices
2028	2085/86	40	1.158	25,980	5,810	14,260	46,040	39,770
2029	2086/87	60	1.216	27,280	9,150	22,460	58,880	48,440
2030	2087/88	80	1.276	28,640	12,800	31,440	72,880	57,110
2031	2088/89	100	1.340	30,070	16,810	41,260	88,140	65,770
2027 to 2031	2084/85 to 2088/89			136,710	47,330	116,200	300,240	242,200
At target, 2025 prices		100	1.000	22,440	12,540	30,790	65,770	65,770

Note: Coverage of every pathway rises in a straight line from current coverage in 2026 to its target in 2031; additional services are phased in at the same pace. Price index relative to 2025 (5% a year). Values are rounded to NPR 10 million. Health Promotion and Ayurveda and Alternative Medicine are not included.

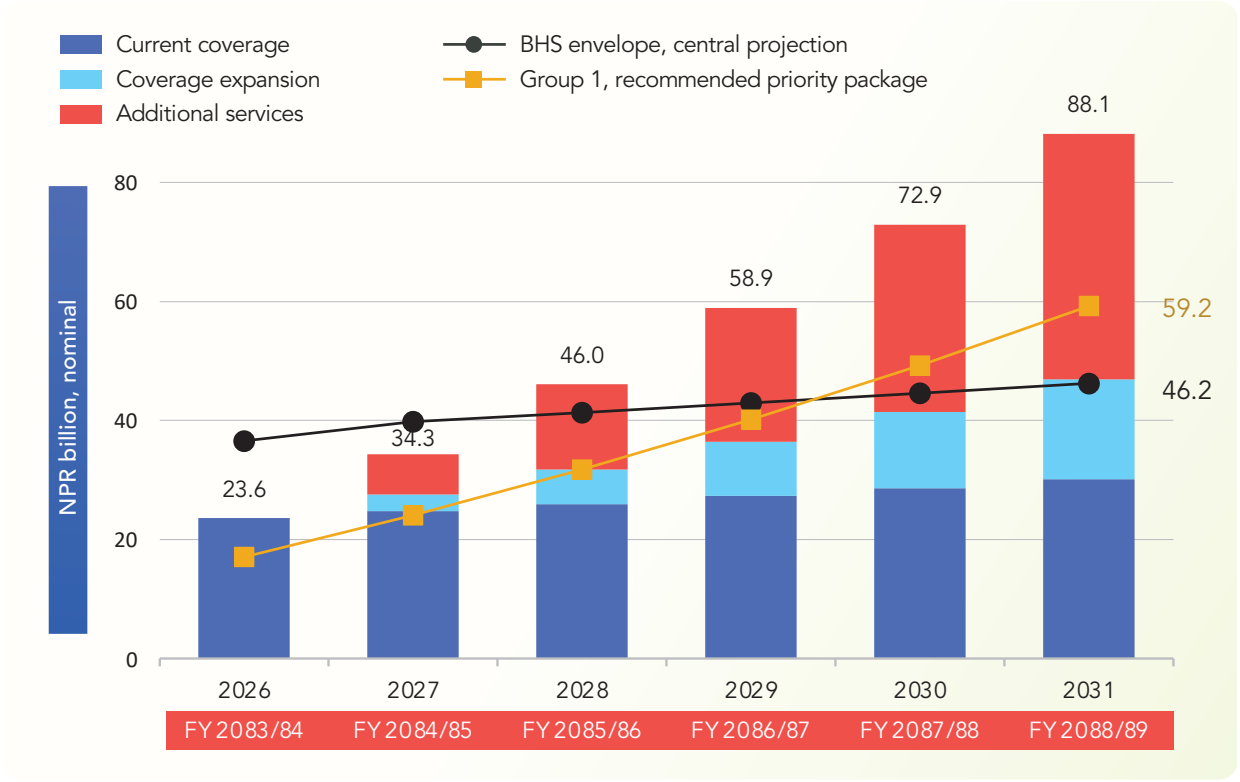


Figure 18: Annual cost of the candidate clinical pathways by component, the cost of Group 1 and the projected BHS envelope, 2026 to 2031 (NPR billion, nominal)

Note: Bars show the annual cost of the 224 candidate clinical pathways by component (Table 21); the lines show the annual cost of Group 1, the recommended priority package, and the central projection of the BHS envelope (Table 24). Calendar years are alignedwith fiscal years as elsewhere in this chapter: 2026 with the approved budget for FY 2083/84 and 2027 to 2031 with FY 2084/85 to 2088/89.

Noncommunicable Diseases and Disability is the largest cluster, at NPR 100.1 billion over five years (33%), followed by RMNCAH-N (NPR 76.4 billion, 25%) and Communicable Diseases (NPR 61.3 billion, 20%) (Table 22). These three clusters account for four fifths of the total. Costs grow fastest where current coverage is lowest: by 2031 the annual cost of mental health services is almost seven times its 2026 level, and that of noncommunicable diseases four and a half times, compared with three times for immunization.

Table 22: Annual cost of the candidate clinical pathways by cluster (NPR million)

Cluster	Pathways	2026	2030	2031	Total 2027 to 2031	Share of total (%)	Annual cost at target, 2025 prices
Immunization Services	12	2,150	5,380	6,380	22,700	7.6	4,758
RMNCAH-N	60	6,570	18,330	21,960	76,360	25.4	16,389
Communicable Diseases	72	5,210	14,730	17,670	61,260	20.4	13,186
NCDs and Disability	49	6,670	24,710	30,300	100,050	33.3	22,609
Mental Health Services	12	790	4,320	5,420	17,020	5.7	4,048
General Emergency Services	19	2,170	5,410	6,410	22,850	7.6	4,783
Total	224	23,560	72,880	88,140	300,240	100.0	65,772

Note: 2026 to 2031 in nominal terms; the last column is the annual cost once all pathways reach their targets, at 2025 prices. Values rounded to NPR 10 million, except the last column.

Table 23 groups the cost by cost effectiveness band. Pathways in the most cost effective band account for NPR 29.7 billion, or 45%, of the annual cost at target, and NPR 136.6 billion over five years. Pathways at or above half of GDP per capita account for 12% (NPR 8.1 billion a year at target), almost half of it for antenatal care, and pathways without a cost effectiveness estimate for 42%.

Table 23: Cost of the candidate clinical pathways by cost effectiveness band (NPR million)

Cost effectiveness band	Pathways	Annual cost at target, 2025 prices	Share (%)	2031, nominal	Total 2027 to 2031, nominal	Cumulative five year total
Below 0.5 × GDP per capita	79	29,742	45.2	39,857	136,599	136,599
0.5 × GDP per capita	13	122	12.3	10,884	35,003	171,602

Cost effectiveness band	Pathways	Annual cost at target, 2025 prices	Share (%)	2031, nominal	Total 2027 to 2031, nominal	Cumulative five year total
No health gain modelled	16	2,382	3.6	3,192	11,692	183,294
No FairChoices match	116	25,526	38.8	34,208	116,889	300,183
Total	224	65,772	100.0	88,141	300,183	

Note: Bands include full and partial matches; six pathways linked to several FairChoices interventions take the band of their best ranked linked intervention. Bands are by pathway: the first row is stream A, the second is stream C, and "no health gain modelled" includes breast cancer screening. The cumulative total adds the bands in the order shown. Five year totals are summed across pathways and differ from Table 21 by less than 0.1%. GDP per capita: US$1,447.7 (2024).

The base case assumes that patients first attend basic health services. If some patients went directly to higher level facilities, where care costs more, the annual cost at target would be NPR 67.4 billion to 85.4 billion, between 2.5% and 30% higher than in the base case, depending on the share of patients and the difference in cost assumed (Section 3.4.4).

4.6.2 Budget impact and affordability

The BHS envelope was NPR 36.6 billion in FY 2083/84, 37.9% of the health budget. Under the central (share based) projection it rises to NPR 39.8 billion in FY 2084/85 and NPR 46.2 billion in FY 2088/89, a five year total of NPR 214.8 billion (Table 24). The two trend methods give a lower total of about NPR 192.2 billion, and applying the latest year share instead of the four year average gives NPR 204.9 billion; at constant FY 2083/84 prices, the central projection is NPR 185.3 billion.[28] The central projection assumes that BHS regain their four year average share of 39.8% of the health budget, after a fall from 42.6% in FY 2081/82 to 37.9% in FY 2083/84.

Table 24: Projected budget envelopes, FY 2084/85 to 2088/89 (NPR million)

Envelope and method	2083/84 approved	2084/85	2085/86	2086/87	2087/88	2088/89	Five year total
BHS core, share based (central)	36,563	39,792	41,314	42,895	44,536	46,241	214,778
BHS core, latest year share	36,563	37,962	39,415	40,923	42,489	44,115	204,904
BHS core, compound growth	36,563	37,174	37,795	38,427	39,069	39,722	192,187
BHS core, linear trend	36,563	37,411	37,929	38,446	38,964	39,481	192,230
BHS core, central, constant 2083/84 prices	36,563	37,897	37,473	37,054	36,640	36,231	185,295
Health promotion and preventive services, central	8,201	9,419	9,780	10,154	10,542	10,946	50,841

Envelope and method	2083/84 approved	2084/85	2085/86	2086/87	2087/88	2088/89	Five year total
Ayurveda basic health services, central	452	350	363	377	392	407	1,889

Note: FY 2084/85 to 2088/89 corresponds to 2027/28 to 2031/32. Central projection: total health budget grown at 3.8% a year and multiplied by each category's four year average share. Constant prices use an illustrative inflation rate of 5% a year. The Ayurveda envelope falls from NPR 452 million in FY 2083/84 to NPR 350 million in FY 2084/85 because the central method applies the four year average share; the allocation for Ayurveda within BHS more than doubled over FY 2080/81 to 2083/84, so its latest share is higher than the average. At the latest share the envelope would be about NPR 2.5 billion over the five years rather than NPR 1.9 billion.

Table 25 compares the cost of the final package with the central projection of the BHS envelope: first Group 1, the recommended package, and then Groups 1 and 2 together, with the cost of all 224 candidate pathways kept as a reference. Both sides are first compared in nominal terms. For the comparison at constant prices, clinical costs have been converted from 2025 prices to FY 2083/84 prices, the base of the envelope projection, so that both use the same price base.

Over the five years FY 2084/85 to 2088/89, Group 1 costs NPR 204.4 billion. This is 95% of the central envelope of NPR 214.8 billion and within the indicative margin of 5% above the envelope that the Steering Committee considered (NPR 225.5 billion), though above the lowest projection of NPR 192.2 billion. The five year total hides a rising profile. Because coverage scales up over the period, the requirement is well below the envelope in the early years, at NPR 24.1 billion against NPR 39.8 billion in FY 2084/85. From FY 2087/88, however, Group 1 alone costs more than that year's envelope (NPR 49.3 billion against NPR 44.5 billion), and in FY 2088/89 it reaches NPR 59.2 billion against NPR 46.2 billion. Group 1 is therefore affordable over the plan period, but sustaining it at full target coverage requires the envelope to grow faster than projected.

Adding Group 2 raises the five year cost to NPR 270.7 billion, NPR 55.9 billion or 26% above the central envelope and NPR 45.2 billion above the 5% margin. The margin left after Group 1, about NPR 21 billion, would pay for roughly a third of Group 2. All 224 candidate pathways would cost NPR 300.2 billion, NPR 85.5 billion (40%) more than the central envelope.

The comparison is indicative rather than exact (Section 3.5.3). The envelope pays for salaries, local programmes, the procurement of medicines and capital grants, while the unit costs value health worker time per service, medicines, consumables and tests, with a 10% overhead on health worker time and a 5% contingency on other inputs, but without equipment. A more telling comparison is between the parts of each that change. Maintaining current coverage of the Group 1 pathways costs NPR 99.0 billion over five years, under half of the central envelope. Expanding coverage and adding services in Group 1 costs NPR 105.4 billion, more than three times the projected growth of the envelope above its FY 2083/84 level, which is NPR 32.0 billion over the same five years. Because the envelope also funds inputs that the unit costs do not value, whether the part of the envelope

above the cost of current coverage is in practice free for scale up will need to be tested in the revision of the BHSP (Section 5.2).

The revised package will therefore need to be phased. Group 1 comes first, with priority in the early years for the most cost effective services and for those that extend coverage to underserved groups, and Group 2 follows as fiscal space grows (Section 5.8).

Table 25: Resource requirement of the final package and the projected BHS envelope, FY 2084/85 to 2088/89 (NPR million)

Requirement, envelope and gap	2084/85	2085/86	2086/87	2087/88	2088/89	Five year total
Group 1, nominal	24,076	31,748	40,128	49,266	59,217	204,435
Groups 1 and 2, nominal	31,113	41,617	53,093	65,613	79,252	270,688
All candidate pathways, nominal	34,300	46,040	58,880	72,880	88,140	300,240
BHS envelope, central projection, nominal	39,792	41,314	42,895	44,536	46,241	214,778
Gap, Group 1 (requirement minus envelope)	−15,716	−9,566	−2,767	4,730	12,976	−10,343
Gap, Groups 1 and 2	−8,679	303	10,198	21,077	33,011	55,910
Group 1 as a share of the envelope (%)	61	77	94	111	128	95
Group 1, constant FY 2083/84 prices	22,930	28,797	34,664	40,531	46,398	173,320
BHS envelope, central projection, constant FY 2083/84 prices	37,897	37,473	37,054	36,640	36,231	185,295
Gap, Group 1, constant FY 2083/84 prices	−14,967	−8,676	−2,390	3,891	10,167	−11,975

Note: Requirement: annual cost of the pathways in each group along the path to target coverage in 2031, with prices rising by 5% a year from 2025; calendar years 2027 to 2031 are aligned with FY 2084/85 to 2088/89. Group 1 excludes the management of wounds and suturing, which is covered within primary trauma care. The row for all candidate pathways repeats Table 21. At constant prices, clinical costs at 2025 prices are multiplied by 1.05 to express them at FY 2083/84 prices. Ayurveda and Alternative Medicine and Health Promotion are budgeted from their own allocations (Table 24) and are not included.

5

Revising And Financing The Basic Health Services Package

5 Revising And Financing The Basic Health Services Package

This chapter considers how the results of the priority setting exercise can inform the formal revision of the BHSP and how the revised package can be financed. It first describes how the prioritized interventions feed into the revision process led by the MoHFS. It then considers the resources required for the prioritized package from several perspectives, the certainty and predictability of the resources available, and options for ensuring adequate financing: expanding fiscal space, clarifying which services are financed through which channels, ensuring predictable financing for local governments, and safeguarding financing for Health Promotion and Ayurveda and Alternative Medicine. The financing context is described in Section 2.3 and is not repeated here.

5.1 From priority setting to revision of the BHSP

The priority setting exercise presented in this report provides an evidence informed foundation for the revision of Nepal's BHSP. By systematically assessing a comprehensive set of candidate interventions against explicit criteria (cost effectiveness, disease severity, equity, policy relevance, social impact and feasibility), the exercise has produced a prioritized package of clinical interventions in three priority groups, together with prioritized Health Promotion and Ayurveda and Alternative Medicine interventions, that reflects both population health needs and system constraints. Each candidate intervention is defined in terms of its scope, appropriate service delivery platform, baseline coverage and cost of scale up to target coverage, which supports a shared understanding among policy, planning and implementation actors of what the package includes and what is expected at each level of care.

The MoHFS has initiated the formal revision of the BHSP, with the intention of updating the list of basic health services specified in the PHSR. Under the Public Health Service Act, 2075 (2018), basic health services are specified in the PHSR, which the Government of Nepal can amend on the recommendation of the MoHFS; the PHSR also allows additional services to be prescribed by notification in the Nepal Gazette (Table 1).[14,15] The revision began in 2026 with a first consultative meeting, which identified the components to be reviewed, such as the scope and content of the package, access and delivery, service readiness, quality, financing, governance and monitoring. The remaining steps are expected to include (i) technical drafting of the revised list and its delivery platforms, drawing on this report; (ii) consultation with provincial ministries, local governments and other stakeholders; (iii) legal review and concurrence on the financial implications by the relevant ministries; (iv) approval by the Council of Ministers and publication in the Nepal Gazette; and (v) dissemination, together with updates to the STPs, Minimum Service Standards and HMIS. The findings of this report are intended to serve as a key technical input to that process, alongside other policy, legal and programmatic considerations that the Ministry will take into account. In this exercise the budget envelope was used to size the package rather than to select individual interventions: the cumulative cost of the priority groups was set against

the projected envelope, and Group 1 was identified as the package that fits the envelope over five years (Section 4.6.2). The formal revision will need to reconcile the package with the resources actually allocated, and in that process stakeholders could revisit which interventions are included, phased in or deferred, drawing on the evidence on costs, cost effectiveness and feasibility presented in Chapter 4.

Table 26 compares the current package with the package proposed in this report.

Table 26: The current and the proposed basic health services package compared

Feature	Current BHSP (PHSR, 2020)	Proposed package (this report)
Legal basis	Article 35 of the Constitution; Public Health Service Act, 2018; PHSR, 2020	Unchanged; revised list to be adopted by amending the PHSR (Section 5.1)
Scope	Ten categories of services described in general terms (Table 1)	300 defined interventions: 204 clinical interventions costed as 224 care pathways, 36 Health Promotion and 60 Ayurveda and Alternative Medicine interventions
Basis for inclusion	Perceived needs and expectations; no explicit criteria	Six endorsed criteria; cost effectiveness; provincial and federal deliberation; national validation
Priorities	None; all services equally guaranteed	Three priority groups for clinical pathways (131, 82 and 11 pathways); three tiers for Health Promotion
Delivery platform	Not specified for each service	Specified for each intervention (Table 20)
Cost	Not costed	Unit cost, population in need, coverage and annual cost for each pathway; Group 1 costs NPR 44.2 billion a year at target (2025 prices)
Link to the budget	BHS envelope follows historical allocation	Cost of Group 1 compared with the projected envelope; benchmark for the Medium Term Expenditure Framework and conditional grants
Conditions of delivery	Not specified	Conditions for 25 pathways, such as tiered chronic care, stabilization and referral, or phased introduction
Monitoring	BHSMS: 102 indicators across nine service areas	Baseline and target coverage for each pathway as a starting point for indicators aligned with the package (Chapter 7)
Review	No regular review	Continuous priority setting linked to planning and budgeting cycles (Section 6.2.2)

Source: Public Health Service Regulation, 2077 (2020);[15] this report.

Beyond the list of interventions, the analytical outputs of this exercise, including estimates of health impact, unit costs, budget implications and delivery platforms, can support alignment between the revised BHSP and related instruments such as standard treatment protocols, financing arrangements and implementation guidelines. Continued technical support from NHEA and BCEPS, alongside contributions from other stakeholders, can support validation

and evidence based refinement of the package through the revision process.

Reforming Nepal's health system requires a coherent policy framework that recognizes the BHSP and health insurance as two interrelated pillars of health financing. Decisions regarding the scope, coverage and financing of one have important implications for the other, and both should therefore be reviewed together within a broader effort to establish an equitable, efficient and sustainable health financing system. Reform of the health insurance system is beyond the scope of this report; health insurance is discussed only to highlight the need for policy alignment with the BHSP (Section 5.5).

A key policy priority is to clarify the scope of services covered under the BHSP, free health care programmes and health insurance. Some interventions currently included in the BHSP may be more appropriately financed through health insurance, while certain services provided under free health care programmes may warrant inclusion in the health insurance benefit package. Such decisions must, however, be consistent with the constitutional guarantee of free basic health services: a service that remains in the BHSP stays free at the point of use, whatever the channel through which it is financed (Section 5.5). Although closely related, free health care services and the BHSP are distinct policy concepts, and their respective entitlements, coverage and financing arrangements need to be clearly defined.

The inclusion or exclusion of services across these arrangements has direct implications for public expenditure, financial protection, equity and the sustainability of health financing. Unclear entitlements, overlapping benefits and fragmented financing arrangements can lead to duplication, inefficient use of public resources and gaps in service coverage. Decisions about which services should be provided free of charge, which should be covered through health insurance and how they should be financed must therefore be informed by a comprehensive assessment of health benefits, costs, distributional consequences and fiscal implications.

The central policy question is not merely how much the interventions included in the BHSP cost, but also how they should be prioritized, delivered, purchased and financed. Resource allocation decisions should consider not only the cost effectiveness and affordability of BHSP interventions but also their implementation modalities, institutional responsibilities, provider payment mechanisms, interactions with health insurance, and implications for the allocation and sustainability of public resources.

What Nepal needs is a coherent health financing architecture that clearly defines service entitlements and financing responsibilities across the BHSP, free health care programmes and health insurance. Such an approach should safeguard the constitutional right to free basic health services, strengthen financial protection, minimize duplication, improve the efficiency and equity of public spending, and support the long term sustainability of the health system.

5.2 Resource requirements of the prioritized package

Prioritizing interventions for the BHSP, estimating their costs, assessing the resource requirements of the revised package and identifying the available fiscal space are essential steps in the policy process. However, creating fiscal space for the prioritized BHSP should not come at the expense of

other health priorities. The objective should be to secure the resources required to implement the prioritized package while safeguarding funding for other essential health programmes and services. Financing decisions must therefore be informed by the broader health sector context, including competing priorities, interlinkages among programmes and the implications of resource allocation for overall health system performance. Accordingly, the financing requirements of the revised BHSP are considered here from several perspectives: the total resources required to implement the prioritized package, existing financing arrangements and expenditure patterns, and the policy goals and fiscal commitments of the Government. Together, these determine the affordability of the revised BHSP, potential financing gaps and options for mobilizing additional resources while protecting other essential health priorities.

Resource requirement perspective. The resource requirement of the revised BHSP is that of the final package (Section 4.6). Delivering the recommended priority package, Group 1, at target coverage would require NPR 44.2 billion a year at 2025 prices once the targets are reached in 2031 (NPR 59.2 billion in nominal terms), or about NPR 1,490 per person, compared with NPR 16.3 billion at current coverage, and NPR 204.4 billion over FY 2084/85 to 2088/89 in nominal terms. With Group 2 added, the annual requirement at target rises to NPR 59.1 billion and the five year requirement to NPR 270.7 billion. For comparison, all 224 candidate clinical pathways would require NPR 65.8 billion a year at target, or about NPR 2,220 per person, and NPR 300.2 billion over five years; about 34% of their cost at target reflects the cost of maintaining current coverage, 19% the cost of expanding coverage and 47% the cost of additional services not yet provided. The largest cost drivers in Group 1 are essential antenatal care, the longitudinal management of type 2 diabetes, primary trauma care, dental care and the prevention of mother to child transmission of HIV. Because unit costs value health worker time per service, with a 10% overhead and no equipment, part of the requirement corresponds to services that are already staffed and partly funded. The incremental requirement, the cost of expanding coverage and adding services, is therefore the more relevant figure for new budget decisions: NPR 105.4 billion over five years in nominal terms for Group 1, against NPR 163.5 billion for all candidate pathways. Unit costs include a 10% overhead on health worker time and a 5% contingency on other inputs, in addition to the 10% wastage on medicines and consumables; together, the overhead and contingency add about NPR 4.2 billion a year to the cost of all candidate pathways at target.

For planning, the MoHFS could adopt the requirement of Group 1 at target coverage as a benchmark for BHS allocations in the Medium Term Expenditure Framework, phasing increases along the scale up path, and could use the cost per intervention to set budget lines for local levels in the conditional grant guidelines (Section 5.6).

Expenditure perspective. Expenditure analysis provides a retrospective assessment of how public resources have been allocated and spent, rather than an estimate of the future resource requirements of the revised BHSP. It helps to identify expenditure patterns, budget execution performance and fluctuations in spending over time, and it is important for assessing the efficiency and predictability

of budget execution and how effectively allocated resources are translated into actual expenditure.

Government budget allocation and expenditure patterns

The patterns of health budget allocation and expenditure described in Section 2.3 are directly relevant to financing the revised BHSP. The share of federal expenditure allocated to health has been unstable, rising sharply during the COVID-19 pandemic and falling back afterwards (Figure 8); the federal government continues to account for most public expenditure, and the shift towards subnational governments during the pandemic proved temporary (Figure 9); conditional grants have grown as a share of federal transfers to local governments while equalization grants have declined (Figure 10); and BHS allocations to local levels fluctuate markedly from year to year (Section 2.3.5).

Together, these patterns show that Nepal's health financing challenges extend beyond the adequacy of budget allocations to their predictability, their distribution across tiers of government and their execution. The fluctuating share of federal expenditure allocated to health, the uneven distribution of expenditure across tiers of government, and the increasing reliance on conditional grants alongside declining equalization grants point to weaknesses in financing stability and fiscal decentralization, which create uncertainty for health sector planning and for the consistent delivery of essential services.

The key lesson is that prioritizing and costing the revised BHSP must be accompanied by predictable financing, clearly defined expenditure responsibilities across tiers of government and effective budget execution. Resource requirements should therefore be assessed alongside historical budget allocations and expenditure, existing financing arrangements and future policy commitments, to identify realistic financing gaps and options for mobilizing additional resources without undermining other essential health priorities.

Distribution of the health budget across tiers of government. Over FY 2080/81 to 2083/84 (2023/24 to 2026/27), the federal level retained on average 56.9% of the MoHFS budget, while local levels received 36.5% and provinces 6.7%, both as conditional grants (Figure 19; Table 4).[28] The local share rose from 35.0% in FY 2080/81 to 38.9% in FY 2081/82, while the federal share fell from 57.8% to 53.7%, a shift towards the local level that is broadly consistent with Nepal's constitutional framework, which assigns local governments key responsibilities for basic health services. The shift was not sustained: in FY 2082/83 the federal share returned to 57.8% and the local share fell to 35.8%, and in FY 2083/84 the shares were 58.0% and 36.1%, respectively. The provincial share fell from 7.4% in FY 2081/82 to 5.8% in FY 2083/84. These shares refer to the MoHFS budget, including the conditional grants it transfers to provinces and local levels; allocations that provinces and local levels make from their own revenue and equalization grants are not included.

Budget allocation, actual expenditure and resource requirements are therefore distinct but complementary dimensions of health financing, and the resource requirements of the revised BHSP need to be read together with the evidence on how resources have been allocated and spent.

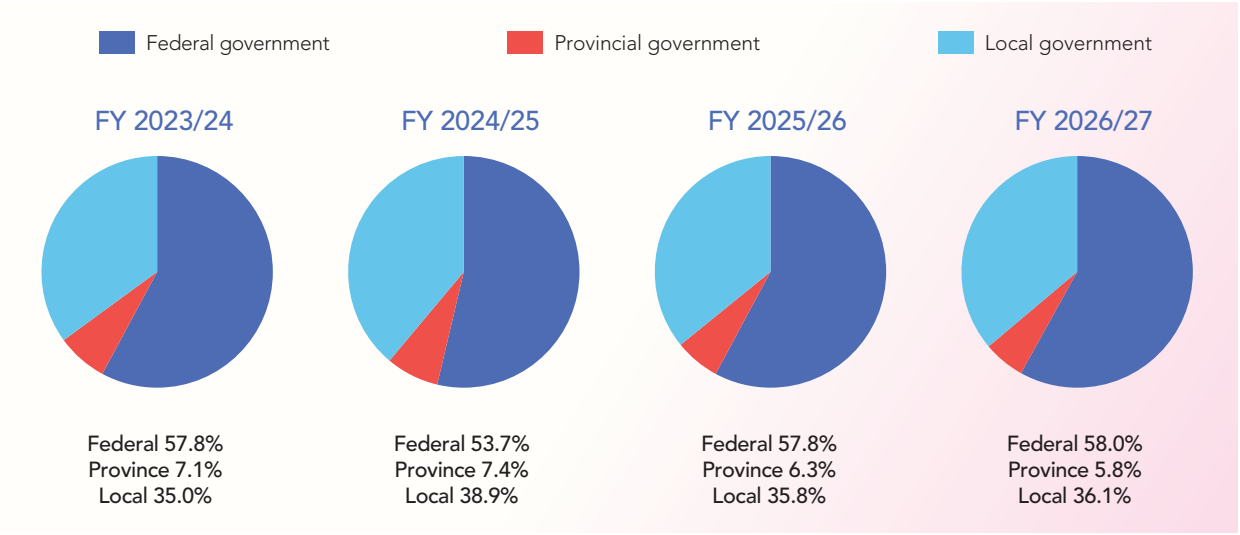


Figure 19: Distribution of the health budget by tier of government, FY 2080/81 to 2083/84 (2023/24 to 2026/27)

Source: Approved annual work plan and budget of the MoHFS, FY 2080/81 to 2083/84.

5.3 Available resources and the financing gap

The analysis of past and current financing patterns highlights two distinct but complementary dimensions of resource adequacy for the revised BHSP: the certainty of the resources available and the total resources required to implement the package. At this stage, the certainty and predictability of available resources are more important than estimating the total resource requirements, and the immediate policy question is how to ensure reliable and sustained financing for the revised BHSP.

This section compares the resources likely to be available for BHS with the resources required for the prioritized package, to give an indicative financing gap. It is not a full fiscal space analysis, which would require estimates of the total resources needed to implement the revised BHSP, an assessment of the resources available from all financing sources, including the own revenue of provinces and local levels, health insurance and external financing, and a comparison of the two. Alongside the size of the gap, it considers the certainty, predictability and sustainability of existing resources and examines whether current financing arrangements can provide a reliable foundation for implementing the revised BHSP.

The projected BHS envelope indicates the resources likely to be available if current allocation patterns continue. Over FY 2084/85 to 2088/89, it amounts to NPR 214.8 billion under the central assumption that BHS keep their four year average share of the health budget, NPR 204.9 billion if they keep their latest share and about NPR 192.2 billion if recent trends continue (Table 24).28 Table 27 sets these envelopes against the resource requirement of the final package. Group 1, at NPR 204.4 billion, is NPR 10.3 billion below the central envelope over the five years and within the indicative margin of 5% above it, but NPR 12.2 billion above the lowest projection; at constant FY 2083/84 prices it is NPR 12.0 billion below the central envelope. The yearly profile matters more than the total: Group 1 exceeds the central envelope from FY 2087/88, by NPR 13.0 billion in

FY 2088/89. Adding Group 2 opens a five year gap of NPR 55.9 billion against the central envelope, about a quarter of it, or NPR 44.0 billion at constant prices. Gaps of this size can be closed only by phasing the package and by expanding fiscal space (Section 5.4).

Table 27: Projected budget envelope, resource requirement and financing gap for the final package, FY 2084/85 to 2088/89 (NPR million)

Envelope, requirement and gap	2084/85	2085/86	2086/87	2087/88	2088/89	Five year total
Budget envelope for basic health services						
Central projection (nominal)	39,792	41,314	42,895	44,536	46,241	214,778
Central projection (constant FY 2083/84 prices)	37,897	37,473	37,054	36,640	36,231	185,295
Compound growth, lowest five year total (nominal)	37,174	37,795	38,427	39,069	39,722	192,187
Indicative level, central projection plus 5% (nominal)	41,782	43,380	45,040	46,763	48,553	225,517
Resource requirement						
Group 1 (nominal)	24,076	31,748	40,128	49,266	59,217	204,435
Group 1 (constant FY 2083/84 prices)	22,930	28,797	34,664	40,531	46,398	173,320
Groups 1 and 2 (nominal)	31,113	41,617	53,093	65,613	79,252	270,688
Groups 1 and 2 (constant FY 2083/84 prices)	29,631	37,747	45,864	53,980	62,096	229,318
All candidate pathways, for comparison (nominal)	34,300	46,040	58,880	72,880	88,140	300,240
Financing gap (requirement minus envelope)						
Group 1 against the central envelope, nominal	−15,716	−9,566	−2,767	4,730	12,976	−10,343
Group 1 against the central envelope, constant prices	−14,967	−8,676	−2,390	3,891	10,167	−11,975
Group 1 against the lowest envelope, nominal	−13,098	−6,047	1,701	10,197	19,495	12,248
Groups 1 and 2 against the central envelope, nominal	−8,679	303	10,198	21,077	33,011	55,910
Groups 1 and 2 against the central envelope, constant prices	−8,266	274	8,810	17,340	25,865	44,023
All candidate pathways against the central envelope, nominal	−5,492	4,726	15,985	28,344	41,899	85,462

Note: FY 2084/85 to 2088/89 corresponds to 2027/28 to 2031/32. The envelope rows repeat Table 24; they reflect the approved allocation pattern of the MoHFS budget, including conditional grants, and exclude allocations that provinces and local levels make from their own revenue and equalization grants, so the gap overstates the additional public resources required to that extent. The indicative level of 5% above the central projection is the margin considered by the Steering Committee; it is not a commitment. The requirement rows show the annual cost of each group along the scale up path to target coverage in 2031, with prices rising by 5% a year from 2025 (Section 3.5.3); at constant prices, clinical costs are expressed at FY 2083/84 prices, the base of the envelope projection. Group 1 excludes the management of wounds and suturing, which is covered within primary trauma care. Ayurveda and Alternative Medicine and Health Promotion are budgeted from their own allocations (Table 24) and are not included. See also Table 25.

The scenarios differ mainly in the share of the health budget that goes to BHS, which fell from 42.6% in FY 2081/82 to 37.9% in FY 2083/84, while the total health budget grew by 3.8% a year. Keeping BHS at their four year average share rather than at their latest share is worth about NPR 10 billion over five years, the difference between the central and latest share scenarios. Protecting the share in this way holds the envelope at its central level, which is what the comparison above already assumes; it does not close the gap that Group 1 opens in the later years, or the larger gap for Groups 1 and 2. That requires a larger health budget, a larger share of it for BHS, or both.

5.4 Expanding fiscal space for basic health services

The policy options for creating fiscal space and for ensuring adequate resources for the revised BHSP overlap substantially, but they require careful interpretation. While fiscal space analysis focuses on identifying additional resources and assessing the gap between available financing and total resource requirements, ensuring resources for the BHSP also requires attention to the predictability, allocation and effective use of existing funds. Potential policy options include mobilizing additional resources at the local level in line with the responsibilities of local governments; improving technical and allocative efficiency to achieve greater health gains from existing expenditure; establishing a minimum federal financing benchmark to ensure a predictable resource commitment across the country; and strengthening conditional grants linked to the delivery of prioritized BHSP services, rather than imposing input based conditions that restrict local spending flexibility. Other options include reprioritizing the health insurance benefit package to align it more closely with the revised BHSP, reducing duplication across financing mechanisms, and improving coordination among federal, provincial and local governments. These options should be assessed in terms of their feasibility, equity implications, sustainability and consistency with Nepal's federal governance arrangements. The objective is not simply to increase funding but to ensure that sufficient, predictable and efficiently used resources are available to deliver the revised BHSP equitably across the country. The options are discussed below in two groups: generating additional resources for health and obtaining more health from existing resources.

5.4.1 Generating additional resources for health

Expanding fiscal space for health in Nepal requires a combination of sustained economic growth, greater budgetary priority for health, improved domestic revenue mobilization, more efficient use of existing resources and a planned transition from external financing. Policy options include increasing public expenditure on health in line with economic growth and national priorities; strengthening tax administration and revenue collection; improving procurement, budget execution and human resource management; and prioritizing cost effective interventions that deliver greater health gains from available resources. Long term planning for the transition from external financing will also be essential to prevent disruptions in essential health services and to ensure the continuity of the revised BHSP.

Economic growth alone will not close the gap if health keeps its current place in the budget. The federal health budget grew by 3.8% a year in

nominal terms between FY 2080/81 and 2083/84, but its share of the national budget fell from 4.9% to 4.5% (Section 2.3.4), and within it the share going to BHS fell from 42.6% to 37.9%.[28] Greater budgetary priority for health, including a gradual increase in its share of the national budget and a protected minimum allocation for BHS within it, is therefore the most direct route to additional resources. Further routes are health related excise taxes and a planned transition from external financing, described below.

Health related excise taxes

Health related excise taxes, commonly referred to as sin taxes, offer a further opportunity. These taxes can be applied to harmful products, including tobacco, alcohol, sugar sweetened beverages and other products associated with adverse health outcomes, such as foods high in salt. When appropriately designed and implemented, they serve a dual purpose: they discourage consumption of harmful products and generate additional domestic revenue. The resulting revenue could help to finance essential health services, strengthen health insurance arrangements and support public health programmes, subject to government budgetary decisions and applicable revenue allocation arrangements.

Nepal already earmarks part of tobacco and alcohol taxation for health through the Health Tax Fund, which financed programmes of NPR 350 million to 400 million a year over FY 2080/81 to 2083/84. Most of this was allocated for the diagnosis and treatment of tobacco related diseases and of breast and cervical cancer, and for hospital equipment and supplies, while activities that can be identified as prevention or awareness received less than 2%.[28] Raising tobacco and alcohol excise in line with the WHO best buys would both reduce consumption and raise revenue: the national investment case estimates that the full package of tobacco control measures would return NPR 26 for every rupee invested over 15 years, with tax increases alone returning 281 to 1.[55,58]

Transition from external financing

External financing is declining and needs a planned transition. The share of the health budget financed by development partners fell from 18.3% in FY 2080/81 to 8.3% in FY 2083/84, and from 45.9% to 13.8% for health promotion and preventive services, much of it for vaccines and programme commodities.[28] Programmes that rely heavily on external support, such as immunization, nutrition, HIV and tuberculosis, will need domestic financing plans with clear timelines so that the transition does not interrupt services. This situation also presents an opportunity to strengthen national self reliance by increasing domestic investment in BHS and using development assistance more strategically, while encouraging partners to adopt more coordinated and sustainable approaches to development cooperation.

5.4.2 Obtaining more health from existing resources

Improving the efficiency of health spending is essential to translating the prioritization of the revised BHSP into better health outcomes. This requires action across three complementary dimensions: allocative efficiency, by shifting resources towards prioritized, cost effective interventions; technical efficiency, by improving procurement, optimizing the use of human resources through task shifting and reforming provider payment mechanisms; and budget execution and public financial

management, by ensuring timely fund release, predictable financing and effective budget execution.

Allocative efficiency

The prioritized package gives an explicit basis for shifting resources towards cost effective interventions. At present, BHS receive about 40% of the health budget, and within local health budgets salaries take 63% and medicines 3% (Section 5.6); measures addressing the risk factors linked to the largest preventable burden receive about 1.4% of the allocation for health promotion and preventive services (Section 5.7).[28] Linking each intervention in the revised package to programme budget codes, as proposed in Section 6.2, would allow allocations to follow the priorities set in this report.

Technical efficiency

Health systems in LMICs face significant resource constraints, with an estimated 20–40% of health spending lost to various forms of inefficiency.[1,59] Countries can improve efficiency by curbing leakage, improving transparency and generating long term savings through preventive care. Evidence from Ghana shows the scale of the problem at the level of primary care: a study of 113 public health centres found that 78% were technically inefficient,[60] and a later study of 151 facilities found that smaller facilities were less likely to be efficient and that redistributing staff could improve efficiency.[61] Operational strategies such as task shifting and optimized procurement can reduce programmatic costs substantially, bridging gaps in access while maintaining service quality.[62,63] Strategic purchasing and provider payment reforms can incentivize cost effective service delivery and link payments to health outcomes rather than inputs. In Nepal, medicine purchases account for about 5% of the health budget, so gains in procurement efficiency would release resources for the prioritized interventions.[28]

These international estimates are context rather than a measure of the funds that can be recovered in Nepal. Four kinds of gain should be kept apart: productivity gains, which deliver more services or better outcomes with the same resources; savings that release cash, such as lower procurement prices, which can be reassigned in the budget; additional fiscal resources, such as revenue from health taxes (Section 5.4.1); and better budget execution, which turns allocations already made into services. Only the last three add to the money available for the package in the short term, and some reforms, such as digital stock management or strategic purchasing, require spending before they yield gains.

Budget execution and public financial management

Approved allocations do not always translate into spending, and capital budgets, which made up between 19.0% and 26.5% of the health budget over FY 2080/81 to 2083/84 and were largely for construction, are particularly prone to underspending.[28] Strengthening the link between technical resource allocation and PFM performance, including more transparent and evidence informed budgeting, will be essential for translating the priorities set in this report into improved health outcomes. Steps that the MoHFS could take include:

i. Using the costing of the revised BHSP to set and justify BHS allocations in the annual work plan and budget and the Medium Term Expenditure Framework;

ii. Tracking budget execution for BHS and Health Promotion quarterly through FMIS and PLAMAHS, by programme budget code and tier of government;

iii. Pooling procurement of medicines and commodities for the prioritized interventions under framework contracts, building on the NHFS; and

iv. Preparing a costed transition plan for externally financed programmes, starting with vaccines and programme commodities.

Improving efficiency therefore requires not only identifying which interventions offer the greatest value for money but also ensuring that allocated resources reach service providers and are used effectively to deliver equitable, high quality health services.

5.5 Aligning financing channels: basic health services and health insurance

As noted in Section 5.1, an explicitly defined BHSP makes it possible to clarify which services are financed through which channel. BHS are free at the point of use and financed through government budgets, while the National Health Insurance Program is intended, as envisaged in the NHFS, to provide financial protection mainly for services beyond BHS at higher levels of care.[12] In practice the two channels overlap: the insurance benefit package covers outpatient, inpatient, diagnostic and medicine services from first service points upwards, up to an annual ceiling of NPR 100,000 for a family of five for an annual premium of NPR 3,500, and many outpatient services and essential medicines at first service points are also part of BHS.

The financial weight of the insurance channel is rising rapidly. Allocations to the Health Insurance Board rose from NPR 7.5 billion (8.7% of the health budget) in FY 2080/81 to NPR 20.2 billion (21.0%) in FY 2083/84, equivalent to 55% of the BHS allocation in that year; over the same period, allocations under the Nursing and Social Security Service Programme fell from NPR 6.1 billion in FY 2082/83 to less than NPR 0.1 billion, suggesting that some targeted schemes are now financed through the insurance channel.[28] Yet only about a third of the population is enrolled (Section 2.3.1), many households do not renew their membership, and payments to providers exceed premium income.[33,36]

Once the revised BHSP is in place, the insurance benefit package could be reviewed to remove or minimize overlap with BHS, so that public budgets finance BHS for everyone and insurance concentrates on referral and specialized care, with clear referral rules from BHS facilities. Figure 20 illustrates this layering: services financed through taxation at the core, services covered through insurance mechanisms around them, and services financed out of pocket at the outer layer. Reducing financial hardship will require stronger public investment, improved service quality and expanded insurance coverage, together with the harmonization of fragmented social security schemes discussed below.

Any change in the channel through which a service is financed must respect the constitutional guarantee. A service that remains in the BHSP must stay free at the point of use for everyone, so it cannot be moved into the contributory insurance package, in which most members pay a premium and only about a third of the population is enrolled. A shift of financing responsibility would be

possible only for services outside the revised BHSP, or after a service has been formally removed from it through amendment of the PHSR following legal review. Cost effectiveness alone would not justify such a shift: the criteria would also include the legal entitlement, the effect on access and enrolment, financial protection for poor and vulnerable households, equity across provinces and the administrative capacity of the Health Insurance Board.

Currently, multiple social security schemes, such as the safe motherhood incentive programme, free newborn care, family planning services, targeted schemes for senior citizens, the immunization programme, the chronic disease support programme for the poor and various communicable disease control programmes, are being implemented to ensure that vulnerable populations are adequately covered and protected from financial hardship. However, financing through multiple schemes with overlapping benefit lists creates a risk of inefficiency, duplication and inequity. Overlap in benefit lists is not in itself waste, since some overlap supports continuity of care; what needs correction is payment for the same service through more than one scheme, and gaps in entitlement between schemes. Three steps can be distinguished: harmonizing benefit lists, so that each service has a defined financing channel; coordinating purchasing, so that providers are paid once for each service; and, as a longer term option that would require legal, fiscal and administrative assessment, integrating the schemes into a single risk pool that enables strategic purchasing, reduces administrative costs and allows cross subsidization between the healthy and the sick, and between the rich and the poor (Figure 20).

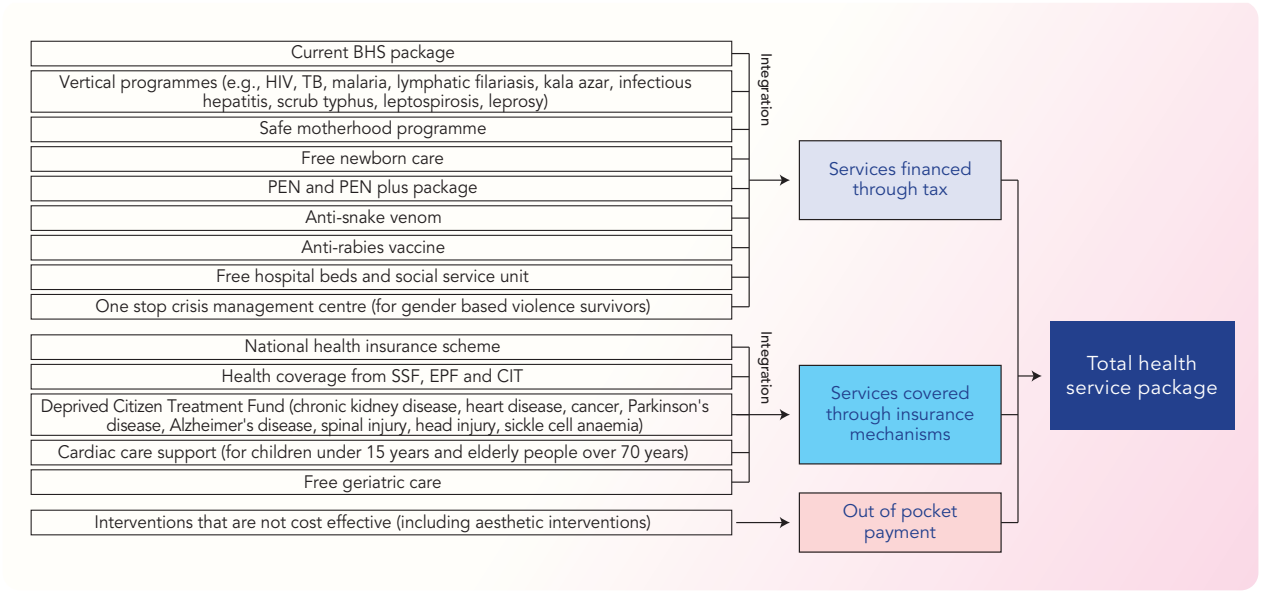


Figure 20: Harmonization of fragmented financing schemes

Note: PEN: Package of Essential Noncommunicable Disease Interventions; SSF: Social Security Fund; EPF: Employees Provident Fund; CIT: Citizen Investment Trust; BHS: basic health services.

Considering the complexity of the issues, the MoHFS will explore short term, medium term and long term strategies for harmonization of health financing schemes (Table 28).

Table 28: Short term, medium term and long term strategies for harmonization of health financing schemes

Period	Strategy
Short term (1–3 years)	Integrate fragmented financing schemes into three broad categories: services financed through taxation, through mandatory progressive health insurance, and through out of pocket payment (Figure 20). Premiums or contributions for the poor to be covered by the Government; for the remaining population, premiums to be charged at progressive rates based on income.
Medium term (4–5 years)	Update the costing of all interventions under the BHSP; review, on criteria that include legal entitlements, equity and financial protection as well as cost effectiveness, whether services outside the revised BHSP should be covered through social health insurance, keeping every BHSP service free at the point of use; and redefine insurance premium amounts accordingly. Using the operationalization support structure described in Section 6.2.1, organize dialogue, decide policy provisions and complete preparatory work for the establishment of a health technology assessment (HTA) system.
Long term (more than 5 years)	Establish and institutionalize the HTA process and decide which services are to be included under the BHSP and health insurance on the basis of HTA results. Once the HTA system is established, the country can carefully assess each new intervention against a predetermined set of criteria to decide its priority and identify an appropriate funding strategy.

These measures should be considered alongside reforms to the health insurance benefit package. Together, a clearly defined BHSP, a complementary insurance package and better harmonized social protection schemes would establish a more integrated financing architecture, with clearer responsibilities, less duplication and a stronger foundation for equitable and sustainable health service delivery.

5.6 Ensuring predictable financing for basic health services at the local level

Local governments receive the largest share of the resources that finance BHS. Over FY 2080/81 to 2083/84, allocations from the MoHFS budget to the 753 local levels averaged NPR 33.2 billion a year (36.5% of the health budget) and grew by 4.9% a year, faster than the health budget as a whole.[28] Most of this is committed to staff: health workforce salaries accounted for 63% of local health allocations, programmes and service delivery for 19%, capital grants for 10% and medicine procurement for 3% (Table 29). Average annual BHS allocations varied widely across local levels, from NPR 11.6 million to NPR 173.9 million (median NPR 38.2 million), reflecting differences in size, population and facility networks.

The flow of resources is also unstable from year to year. Between 18.5% and 26.7% of local levels saw their BHS allocation change by more than 20% from one year to the next, and the number of local levels receiving capital grants for health fell from 651 in FY 2080/81 to 141 in FY 2081/82 and 85 in FY 2083/84, while the total capital grant fluctuated between NPR 2.1 billion and NPR 4.8 billion.[28] Such volatility makes it difficult for local governments to plan staffing, procurement and the expansion of services.

Table 29: Health allocations to local levels by component, FY 2080/81 to 2083/84 (NPR million)

Component	2080/81	2081/82	2082/83	2083/84	Average	Share (%)
Health workforce salaries	20,644	20,314	20,511	21,652	20,780	62.8
Programmes and service delivery	5,897	5,901	6,606	7,300	6,426	19.3
Capital grants (infrastructure and equipment)	2,306	4,811	4,673	2,131	3,480	10.4
Medicine procurement	1,295	1,005	1,021	1,004	1,081	3.3
Grants to hospitals or institutions	34	13	62	353	115	0.3
Monthly NPR 5,000 patient support (outside BHS)	0	1,392	1,456	2,389	1,309	3.8
Total local level allocation	30,177	33,436	34,329	34,830	33,193	100

Note: Share is the four year average of annual proportions. Allocations from local governments' own revenue and equalization grants are not included.

Source: Approved annual work plan and budget of the MoHFS, FY 2080/81 to 2083/84.

Reforms for predictable financing

Under Nepal's federal system, basic health services are constitutionally mandated to be delivered at the local government level. In principle, this requires a predictable flow of resources to municipalities. Conditional grants, if well designed and stable, could serve as a key instrument for ensuring the delivery of basic health services. However, the current pattern is characterized by wide year to year fluctuations in both the size and the structure of these transfers. This instability undermines planning, disrupts service continuity and prevents local governments from building durable capacity for BHS implementation.

The core challenge, therefore, is not only the level of resources but also the streamlining, predictability and alignment of budget allocations with the priorities established through the BHS process. Without a minimum financing guarantee for essential services, prioritization alone cannot produce the expected health gains. Achieving the expected outcomes requires that the prioritized interventions be backed by stable public financing, clear budget lines and timely disbursement mechanisms.

Looking forward, health sector reforms must be accompanied by reforms in PFM and intergovernmental fiscal transfers. These include:

i) Ensuring a protected minimum allocation for BHS delivery;

ii) Improving budget execution and utilization rates at all tiers of government;

iii) Strengthening the design of conditional grants to reduce volatility and improve accountability; and

iv) Revisiting the structure of equalization grants to ensure that constitutional responsibilities for basic health services are adequately financed.

Achieving this will require coordinated action beyond the health sector, engaging the MoF, the National Planning Commission, provincial and local governments, and development partners, to ensure that fiscal federalism arrangements support the effective implementation of the BHSP.

A minimum budget floor for basic health services would help to ensure that every citizen, regardless of geographical location or local fiscal capacity, receives a guaranteed level of care. To guarantee comparable access, the minimum would need to be set by a needs based formula rather than as a flat amount. Factors that could inform it include the population and its age and sex structure; measures of need, such as survey based indicators of mortality and morbidity rather than the demographic estimates of burden in Section 2.1.5; the number, type and readiness of facilities; and the cost of delivery, with a premium for remote and hard to reach areas, where transport, outreach and staff retention cost more (Section 8.2). The calculation would also need to be clear about which revenues count towards the minimum: MoHFS conditional grants, the part of equalization grants used for health and local governments' own revenue, not all of which are captured in the MoHFS budget data used in this report (Section 2.3.5). Because local governments vary widely in their revenue raising ability, resource poor local governments would receive proportionally higher allocations, while those with stronger revenue bases could rely more on their own resources to fund the same package.

Such redistribution can improve the equity and efficiency of allocation, but it cannot be assumed to close an aggregate financing gap. The comparison in Section 5.3 shows that Group 1 exceeds the central envelope from FY 2087/88 and that Groups 1 and 2 together exceed it by about a quarter over five years, so redistribution will need to be combined with a larger health budget, a larger share of it for BHS, or both. Additional resources will also be required for services beyond the package, such as specialized care, infrastructure and system strengthening. Keeping these two needs apart is important for fiscal sustainability while upholding universal access to essential services.

5.7 Financing health promotion and Ayurveda and alternative medicine

Health Promotion and Ayurveda and Alternative Medicine interventions were prioritized through deliberative processes rather than cost effectiveness analysis (Section 3.5), and their costs were only partly estimated in this round (Section 4.2.2). There is a risk that interventions without quantitative estimates receive less attention when resources are allocated. This section considers how financing for these interventions can be safeguarded, given their importance in responding to the growing burden of NCDs and their place in the BHS defined in the PHSR.

Current financing. Health promotion and preventive services, defined following the preventive care function of the System of Health Accounts, received an average of NPR 8.52 billion a year over FY 2080/81 to 2083/84 (9.4% of the health budget), but the allocation fell by 3.7% a year, from NPR 9.19 billion to 8.20 billion, as external financing for this area fell from 45.9% to 13.8%.[28] Immunization accounts for 54% of this envelope and FCHV and school health for 18%. Health education, information and communication, the core of Health Promotion, received NPR 0.39 billion a year (4.7%), and allocations linked

to NHEICC at federal, provincial and local levels fell from NPR 181 million in FY 2080/81 to NPR 146 million in FY 2083/84. Measures addressing tobacco, alcohol and NCD risk factors, which are linked to the largest preventable burden (Section 4.4.1), receive about 1.4% of the envelope.[28] Ayurveda and Alternative Medicine received NPR 1.33 billion a year (1.5% of the health budget), growing by about 13% a year; 60% of it is allocated at the federal level, and the part delivered within BHS rose from NPR 0.19 billion to 0.45 billion, around 1% of the BHS envelope.[28]

Protecting their share. Because these interventions lack the quantitative estimates that support clinical interventions, they risk being crowded out when budgets tighten. Three options could safeguard them: (i) a protected minimum allocation for each, for example keeping health promotion and preventive services at no less than their four year average share of 9.4% of the health budget, and ring fencing within it a floor for the first tier Health Promotion themes, such as 5% of the envelope (about NPR 0.47 billion to 0.55 billion a year over FY 2084/85 to 2088/89); (ii) earmarking a larger part of the Health Tax Fund, and of any new health taxes, for prevention rather than treatment; and (iii) explicit budget lines for Health Promotion and Ayurveda services in the conditional grant guidelines for local levels, so that delivery through FCHVs, schools, Aushadhalaya and Nagarik Aarogya Kendra is funded predictably. The evidence on returns supports such protection: public health interventions return a median of 14 times their cost,[64] NCD best buys return at least US$7 for every dollar invested in low and lower middle income countries,[65] and in Nepal the tobacco control package returns NPR 26 for every rupee over 15 years.[58]

These percentages are policy benchmarks rather than costed requirements. The 9.4% share is the historical share of health promotion and preventive services, an envelope in which immunization accounts for 54% and FCHV and school health for 18%, so it protects much more than the 36 Health Promotion interventions; the floor of 5% within it is intended for the first tier Health Promotion themes, the tobacco, alcohol, nutrition and NCD risk measures that now receive about 1.4% of the envelope. For Ayurveda and Alternative Medicine, a protected allocation would finance the services already delivered through Aushadhalaya and Nagarik Aarogya Kendra, and any expansion would depend on a review of their evidence and safety. Both benchmarks could be replaced by costed requirements once Health Promotion interventions are costed and the population in need for Ayurveda services is known.

Strengthening the evidence. Future rounds could cost Health Promotion interventions, starting with the first tier themes, and generate evidence on the use and outcomes of Ayurveda and Alternative Medicine services through AHMIS, so that both categories can be assessed alongside clinical interventions (Section 6.2.2).

5.8 The way forward: phasing the package to 2030

Financing the revised BHSP will need to be sequenced alongside its formal adoption (Section 5.1) and implementation (Chapter 6). In the short term, the priority is to protect what already exists and to begin with Group 1: a minimum allocation for BHS and floors for Health Promotion and Ayurveda services, aligned conditional grant guidelines, and a costed plan for the transition from external financing. Within Group 1, the early years could

give priority to extending services that are already provided to the people not yet reached, particularly through basic health service centres and community platforms, alongside the gradual addition of new service content, since this costs less and serves equity directly (Section 4.6.1); the order of priority between pathways remains that of the groups. In the medium term, the scale up of Group 1 towards its 2031 targets would be matched by a rising share of the national budget for health, higher health taxes and the harmonization of financing schemes, and Group 2 would be phased in as fiscal space allows, guided by burden, equity and facility readiness. In the long term, an institutionalized HTA process would decide the scope of the BHSP and the insurance benefit package, the deferred pathways in Group 3 would be reconsidered, and later rounds of priority setting would treat the budget envelope as a constraint on selection, so that the package can be expanded progressively as fiscal space grows (Table 30).

Table 30: Phasing of financing measures for the revised BHSP

Phase	Financing measures	Link to the package
Short term (FY 2084/85 to 2085/86)	Protected minimum BHS allocation in the annual budget; floors for Health Promotion and Ayurveda services; conditional grant guidelines aligned with the revised package; costed transition plan for vaccines and programme commodities	Adoption of the revised BHSP through the PHSR, starting with Group 1; costing of Group 1 used in the Medium Term Expenditure Framework; review of overlap with the insurance benefit package
Medium term (FY 2086/87 to 2087/88)	Rising health share of the national budget; higher tobacco and alcohol excise with part earmarked for prevention; harmonization of social security schemes (Table 28); improved budget execution	Scale up of Group 1 towards its 2031 targets; Group 2 phased in as fiscal space allows; preparatory work for HTA; second round of costing, including Health Promotion
Long term (beyond 2030)	Budget envelope used as a constraint in priority setting; progressive expansion as fiscal space grows	Institutionalized HTA deciding the scope of the BHSP and insurance; Group 3 reconsidered; continuous priority setting (Section 6.2.2)

6

Implementation Of The Revised Basic Health Services Package And Health System Reforms

6 Implementation Of The Revised Basic Health Services Package And Health System Reforms

This chapter looks ahead to the period after the formal revision of the BHSP described in Section 5.1. It sets out how the revised package could be implemented and institutionalized within existing government structures, including arrangements for keeping the package up to date through continued priority setting. It then outlines health system reforms, organized around the health system building blocks, that the revised package would require and could help to guide, and ways of preparing the health system to sustain basic health services during outbreaks and other emergencies. Financing of the revised package is discussed in Chapter 5, and monitoring and evaluation in Chapter 7.

The directions presented in this chapter draw on the experience and observations of those involved in the priority setting exercise, built through sustained engagement with the health system at the federal, provincial and local levels, and on the policy documents reviewed for this report. They are not based on a dedicated assessment of each part of the health system and are therefore intended as indicative directions to inform further discussion and detailed planning during implementation of the revised BHSP.

6.1 Implementation of the revised basic health services package

Once revised, implementation of the BHSP would represent a major milestone towards achieving UHC by 2030. Beyond identifying priority health services, the revised BHSP can act as a strategic driver of health system strengthening, reinforcing governance, financing, service delivery, the health workforce, health information systems and access to essential medicines. Through its implementation, the BHSP can help to ensure that improvements in service coverage, equity and financial protection are underpinned by systemic reforms that enhance efficiency, transparency and resilience.

Following the revision of the BHSP, the MoHFS is expected to take forward its implementation as an integral part of Nepal's broader health system architecture. The revised BHSP is intended to function not merely as a list of cost effective interventions but as a coherent implementation framework embedded within existing health system structures and processes. Its implementation could be closely linked to strengthening the six health system building blocks and aligned with the NHSSP and the NHFS, supporting a gradual transition from fragmented, programme based service delivery towards a more coordinated, people centred and resilient health system.

Through this approach, implementation of the revised BHSP could provide a practical pathway for operationalizing the NHSSP's vision of an equitable, efficient and high quality health system that ensures access to essential health services without financial hardship. By prioritizing evidence based and cost effective interventions that address the country's major causes of morbidity and mortality, the BHSP can support improved financial protection, social inclusion and more effective use of public resources as Nepal advances towards UHC.

Implementation need not wait until every guideline, protocol and reporting

form has been revised. Most Group 1 pathways are already delivered in some form, so the revised package can be introduced in stages, with protocols, training and reporting tools updated as implementation proceeds and lessons are fed back. This approach of reform on the move would allow early gains while the more demanding changes, such as new diagnostics, tiered chronic care or referral arrangements, are prepared (Section 6.3.2).

Experience from Pakistan, which designed its essential package of health services with support from the DCP3 country translation project, is relevant for a federal system. Pakistan defined a full package of 117 interventions but, because government allocations fell short of its cost, began with an immediate implementation package of 88 district level interventions, to be extended as allocations increase; the national package also guided the development of provincial packages through the same evidence informed process.[66] The main challenges identified for the transition to implementation were strengthening national technical capacity, institutionalizing priority setting and package revision within ministries of health, addressing health system gaps and closing the financing gap progressively.[66] Group 1 plays a similar role in Nepal to Pakistan's immediate implementation package, and provinces could adapt the national package in the same way within Nepal's federal arrangements.

6.2 Institutionalization and integration

Following formal endorsement, the revised BHSP would need to be embedded into existing health system structures to support sustainable implementation. Institutionalization moves the BHSP from a list of services to a routine operational framework guiding service delivery, financing and governance. The governance structures established for the priority setting exercise, namely the Steering Committee and the TWC (Chapter 3), could continue to guide planning, supervision and coordination across levels of government during implementation. Implementation guidelines could set out the roles and responsibilities of federal, provincial and local governments, in line with Nepal's federal governance structure. Integration into existing NHSSP coordination mechanisms, such as joint annual reviews, SWAp frameworks and thematic working groups, could provide a platform for harmonized policy and partner support.

Another core component of institutionalization is financing integration. The costs of the revised BHSP could be synchronized with Nepal's Medium Term Expenditure Framework and informed by fiscal space analysis under the NHFS, and each BHS intervention could be linked to programme based budget codes, allowing better tracking of expenditure and outcomes. Options for financing the revised package are discussed in Chapter 5.

The WHO guide on institutionalizing health technology assessment mechanisms offers a framework for this process.[67] It sets out the elements that a lasting mechanism needs, among them a clear mandate and legal basis, defined institutional arrangements, explicit processes for selecting topics, assessing and appraising evidence and reaching decisions, stakeholder involvement and transparency, technical capacity and sustainable financing. Reviewing the arrangements proposed in this chapter against these elements, and drawing on comparable frameworks

for evidence informed priority setting being developed in other regions, could guide the phased move from this exercise to an institutionalized HTA process (Section 6.2.2; Table 28).

Facility readiness, including infrastructure, equipment and diagnostics, is discussed in Section 6.3.3, and the updating of service delivery protocols and strengthening of the referral system in Section 6.3.2.

6.2.1 Operationalization support structure at the federal level

To ensure that the revised BHSP remains responsive to evolving health needs and is implemented in a systematic and sustainable manner, an operationalization support structure at the federal level would be important. Such a structure would enable continuous technical work on the BHSP beyond the one time revision exercise, particularly in relation to emerging interventions, refinement of existing services, and associated costing and budget impact analysis (Figure 21).

At the operational level, a technical team housed within the DoHS could play a central role in identifying, defining and refining candidate interventions. This team would be responsible for continuously scanning new or emerging interventions, clarifying what each intervention entails, specifying the intended service delivery platforms, and undertaking follow up technical work on interventions included in the revised BHSP, especially where further costing, coverage assumptions or implementation details need to be refined over time.

Complementing this, a Health Economics and Analytics Team, a new unit that would need to be established within the Policy, Planning and Research Division (PPRD) of the MoHFS, could provide analytical support to inform decision making. This team would focus on synthesizing economic and analytical evidence, including cost effectiveness, budget impact, affordability and distributional implications, working closely with the DoHS technical team to assemble a consolidated evidence package. This function would strengthen the Ministry's capacity to apply economic evidence routinely to policy and programme decisions related to the BHSP.

At the decision making level, a formal decision authority, such as a Steering Committee or equivalent body chaired by the Secretary of Health or a designated senior official, would provide strategic oversight and final endorsement. This body would review the evidence assembled by the technical and analytical teams and take decisions on inclusion, modification, sequencing or deferral of interventions within the BHSP, ensuring alignment with national priorities, fiscal space and policy commitments.

Together, this three tier structure would establish a clear and transparent pathway from technical identification and definition of interventions, through rigorous analytical appraisal, to informed and accountable decision making. Such an arrangement could help to institutionalize evidence informed priority setting within routine government processes and support the dynamic management of the BHSP over time.

The federal structure would also need defined links with the provinces and local levels (Figure 21). Provincial ministries of health and health directorates could contribute appraisals of feasibility in their provinces, as in the provincial deliberations, coordinate referral between basic hospitals and provincial hospitals, and support supply chains through provincial distribution

hubs. Local government health sections, which hold the constitutional responsibility for delivering BHS, could report on facility readiness, budget execution and service delivery, and raise implementation problems through the review processes described in Section 7.5.

6.2.2 Priority setting as a continuous process

The exercise documented in this report was the first systematic round of priority setting for Nepal's BHSP. For the revised package to remain relevant as the disease burden, available technologies, costs and fiscal space change, priority setting could become a continuous function rather than a one time exercise. The operationalization support structure described in Section 6.2.1 offers an institutional home for this function.

Embedding priority setting in routine planning and budgeting. Linking priority setting to existing planning and budgeting cycles, such as annual work planning and budgeting, the Medium Term Expenditure Framework and periodic reviews of the NHSSP, could help to ensure that decisions on adding, scaling up or phasing out services are informed by evidence on costs, health gains and equity at the point when resources are allocated.

Continuous contextualization and evaluation of interventions. The cost effectiveness analysis for Nepal could be updated as new local evidence on coverage, costs and effectiveness becomes available, including from routine information systems (Chapter 7) and targeted costing studies. Interventions in the package, as well as new or emerging interventions identified by the DoHS technical team, could be reevaluated regularly so that the analysis remains useful for policy decisions in Nepal's context.

Strengthening the process in future rounds. Future rounds could extend

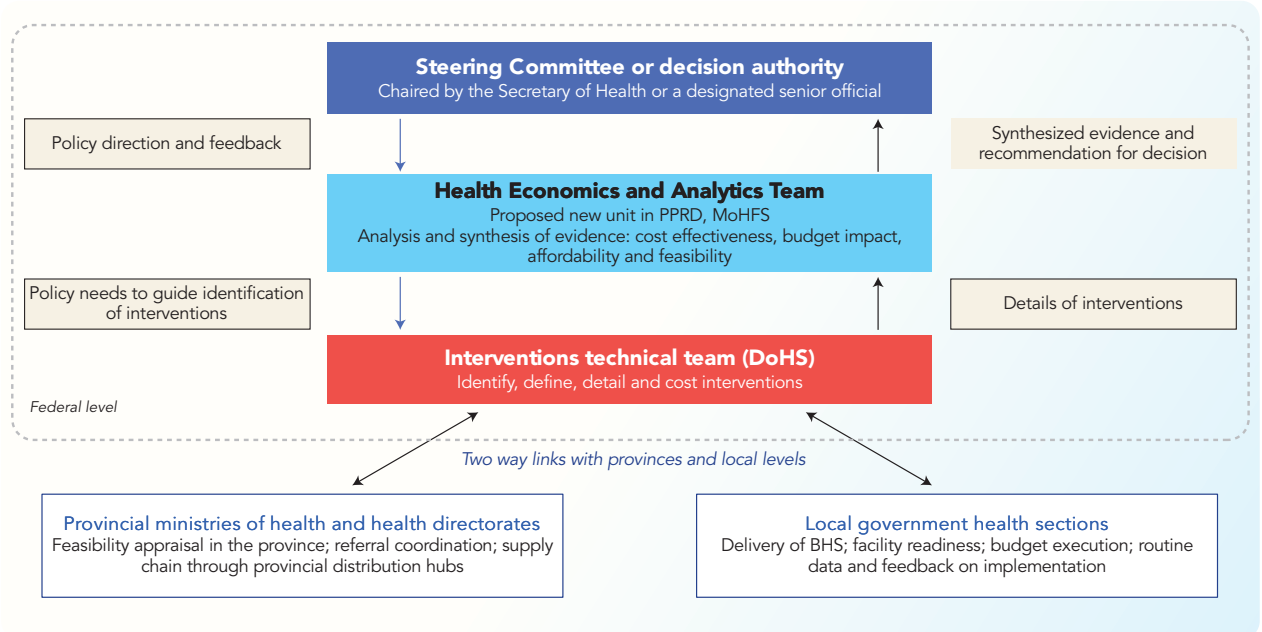


Figure 21: Operationalization support structure at the federal level and its links with provinces and local levels

structured deliberation beyond the buffer zone, so that interventions further from the cost effectiveness threshold are also reviewed against equity, policy relevance, social impact and feasibility. Generating evidence on the effectiveness, coverage and costs of Health Promotion and Ayurveda and Alternative Medicine interventions could allow these to be assessed alongside clinical interventions (Section 3.5.2). In the formal revision of the BHSP and in future rounds, the budget envelope would serve as a constraint on the selection of interventions rather than only as an affordability check (Section 5.1). For clinical interventions without a FairChoices counterpart, future rounds could also draw on other sources of evidence on health gains, such as published cost effectiveness studies and international databases, as Ethiopia did when it combined several criteria and sources of evidence in revising its essential health services package.[68]

Over time, these functions could form the basis of a health technology assessment process to inform decisions on the scope of the BHSP and the health insurance benefit package (Section 5.5, Table 28).

6.3 Health system reforms for basic health services

6.3.1 Leadership and governance

Implementation of the revised BHSP can help to institutionalize transparent and evidence based decision making across all levels of government. The support structure described in Section 6.2.1 could serve as the governance mechanism that helps to ensure that health priorities are set collaboratively and grounded in epidemiological evidence, cost effectiveness, equity, policy relevance, social impact and feasibility. The two technical teams, supported by a decision authority in the form of a steering committee or similar body, could coordinate the design, implementation and review of the BHSP, promoting consistency across federal, provincial and local levels.

With the transition to a federal structure, BHS delivery largely falls under the jurisdiction of local governments, which brings challenges in policy coherence, governance and accountability. To support smooth implementation and equitable access, the MoHFS could focus on improving policy coherence across the three tiers of government, strengthening institutional capacity, reducing fragmentation, improving accountability and fostering effective stewardship in the spirit of federalism.

6.3.2 Service delivery and referral systems

Integrated services

The revised BHSP defines an integrated service delivery model anchored in delivery platforms, which can support continuity of care across preventive, promotive, curative, rehabilitative and palliative services and the integration of preventive, promotive and basic curative services at BHS facilities. Where appropriate, integration of Ayurveda and Alternative Medicine services within the same BHS facilities could also be considered, supported by clear procedures, clinical guidelines and referral linkages to ensure safety, quality and coherence with the broader health system.

Updating protocols

Implementation of the revised BHSP would involve updating or revising standard operating procedures (SOPs), STPs, clinical guidelines and supervision protocols to ensure quality and consistency. The revised BHSP could also promote integration of

services across vertical programmes, making service delivery more efficient and client centred, in line with the NHSSP priority of integrated service delivery and improved quality of care across all levels of the system.

Strengthening the referral system

Strengthening the referral system could build on the existing referral guidelines developed by the DoHS. These guidelines could be reviewed and, where required, updated to align with the revised BHSP, including the prioritized interventions, defined service delivery platforms and tier specific roles. Refining existing referral protocols, rather than introducing new parallel systems, could help to reduce bypassing, improve continuity of care and make more efficient use of higher level services.

Given resource constraints, challenging geography and varying health system capacity, it is neither feasible nor desirable to expand higher level services across all local governments. A strong referral system that reinforces primary care as the foundation of service delivery, while ensuring effective linkages to secondary and tertiary care, is therefore important. This could be supported by tiered referral protocols and digital records linking BHS facilities with provincial and federal hospitals and specialized centres. Integrating ambulance services within the referral mechanism, particularly in remote areas with limited transport options and referral facilities, could further improve timely access to appropriate care. Aligning referral protocols with digital health initiatives, including electronic referrals and patient tracking systems, could strengthen continuity of care and accountability and enable monitoring of referral appropriateness and outcomes.

Inclusion in the package does not mean that every intervention can be delivered immediately at its designated platform. Table 31 groups the 131 Group 1 pathways by what their delivery depends on, drawing on the conditions agreed at validation and the feasibility findings of the provincial deliberations (Section 4.3.1; Annex 4). Most can be delivered on existing platforms with routine attention to medicines, supplies and staff; a smaller set needs investment in readiness or a phased introduction; and a third set depends on screening, stabilization and referral arrangements that work in practice.

Table 31: Group 1 pathways by what their delivery depends on

What delivery depends on	Pathways	Cost at target (NPR billion a year)	Examples	What is needed
Existing platforms, with routine readiness	116	35.6	Immunization, family planning, maternal and newborn care, common infections, tuberculosis, programme commitments	Medicines, supplies and staff in line with the Minimum Service Standards
Readiness investment or phased introduction	8	5.5	Tiered chronic care for diabetes, cardiovascular disease and COPD; basic physiotherapy; burn care; dementia and PTSD; primary palliative care	STPs, trained staff, diagnostics and medicines at each tier; phased roll out

What delivery depends on	Pathways	Cost at target (NPR billion a year)	Examples	What is needed
Screening, stabilization and referral	7	3.1	Primary trauma care; screening for cervical, oral and colorectal cancer; emergency care of stroke and ischaemic heart disease; child and adolescent mental health	Referral links and transport that reach care in time; capacity at referral hospitals
Total	131	44.2		

Note: Classification by the conditions attached at validation (Annex 3). Programme commitments and blanket distribution (five pathways with conditions that do not affect readiness) are counted in the first row. Cost at 2025 prices. COPD: chronic obstructive pulmonary disease; PTSD: post traumatic stress disorder.

Focus on people centred care and quality enhancement

The Government of Nepal recognizes that health services must be delivered in a respectful, culturally appropriate and responsive manner to foster trust and reduce care avoidance. In line with this, the MoHFS has placed increasing emphasis on adolescent friendly, disability friendly and geriatric friendly services, building on existing policies, guidelines and programmatic experience. Ongoing efforts have focused on developing and refining service delivery guidelines, strengthening the capacity of health workers, and progressively improving the physical environment of health facilities to make them more inclusive and responsive to the needs of these population groups.

As implementation advances, the MoHFS could build further on this progress by institutionalizing inclusive service standards within the revised BHSP and aligning training, supervision and facility readiness with these priorities. Where appropriate, the Ministry could work jointly with relevant stakeholders and HDPs to support capacity development, infrastructure improvements and monitoring of service quality, so that people centred and inclusive care remains an integral part of Nepal's health system strengthening efforts.

Technological innovations in health

Expanding telemedicine services can play a key role in improving access to health care in Nepal, given the country's difficult geography, scattered rural settlements, acute shortage of human resources for health and limited health infrastructure in remote areas. Many populations in mountain and hill regions face long travel times and high costs to access BHS, which delays care and reduces service use. Telemedicine can help to bridge this gap by connecting basic health service centres and basic hospitals with doctors and specialists in provincial and federal hospitals through remote consultations, digital diagnosis and follow up services. This approach can improve access to specialist care, support rural health workers in clinical decision making, reduce unnecessary referrals and travel costs, contribute to capacity development of the health workforce at the peripheral level, and strengthen the overall efficiency and equity of the health system. Expanding telemedicine could therefore be considered as a key strategy for underserved and rural areas of Nepal.

6.3.3 Essential medicines, diagnostics, equipment and infrastructure

Facility readiness: infrastructure, equipment and diagnostics

The provincial deliberations identified shortages of human resources for health and gaps in physical infrastructure as the main constraints on delivering several candidate interventions through BHS platforms (Section 4.3.1). With the delivery platform of each prioritized intervention now specified, facility readiness assessments could identify the infrastructure, equipment and diagnostic capacity that each platform needs to deliver the revised package, building on the Minimum Service Standards and on information from the NHFR and HIIS. Diagnostic capacity, including basic laboratory services and point of care tests, is particularly important for the many interventions in the package that depend on screening, confirmation of diagnosis and follow up testing, especially for NCDs and communicable diseases. Plans for equipment could also cover maintenance and replacement, so that investment remains functional over time.

Given resource constraints, upgrading could be phased and differentiated by platform and location, giving priority to the requirements of the most cost effective interventions and to underserved areas, while services beyond the capacity of BHS facilities are reached through referral (Section 6.3.2). Where possible, infrastructure such as laboratory networks and oxygen supply could serve routine needs and be scaled up during surges (Section 6.4).

Updating the list of essential medicines

Implementation of the revised BHSP would call for updating the National List of Essential Medicines in line with the prioritized interventions, so that all core services have reliable access to the required medicines, vaccines and diagnostics.

Strengthening supply chain management

Limited availability of essential medicines and medical supplies in public facilities has remained one of the key challenges over the last few decades and can undermine the coverage and impact of the BHSP in Nepal: in 2021, only 1% of public health facilities had all 20 tracer medicines available.[29] Data driven, morbidity based forecasting of medicines and other commodities offers one option to overcome this challenge, and the implementation of electronic health records in public facilities could be a key step towards such forecasting. Scaling up the Public Assets Management System (PAMS) with real time mobile applications for health facility stock reporting, linked to DHIS2 for end to end visibility and automated reorder alerts, can help to ensure the availability of essential medicines. Centralized procurement and well managed supply chain programmes have been shown to generate cost savings and reduce stockouts in LMICs.[62] Further, gradual upgrading of cold chain infrastructure in remote districts, while decentralizing distribution hubs to the provincial level under federalism, could support faster delivery of commodities to rural areas. Expediting these reforms, in line with the efficiency measures of the NHFS 2023–2033, would directly support the delivery of the revised BHSP.[12]

Scaling up in country production capacity

Developing in country manufacturing capacity for selected essential medicines and vaccines could reduce reliance on imports and help to ensure continuous supply. Global pharmaceutical supply chains are vulnerable to geopolitical and economic shocks, which can lead to shortages that undermine the delivery of BHS. Over time, Nepal could consider strengthening domestic production of selected essential medicines, supported by appropriate quality regulation.

6.3.4 Strengthening health workforce capacity

Addressing the persistent shortage of health workers

Effective implementation of the revised BHSP would require addressing critical gaps in human resources for health by promoting equitable distribution, task shifting and a health workforce with an appropriate skill mix. An assessment of current staffing levels across BHS delivery platforms could be an important first step, guiding targeted deployment so that underserved and hard to reach areas receive an adequate health workforce. Task shifting of selected basic services (for example, aspects of maternal care) from doctors to nurses and other midlevel providers could help to extend service coverage and allow doctors to focus on care that requires their skills. Task shifting would also require the scopes of practice and prescribing rights set by the Nepal Medical Council, the Nepal Nursing Council and the Nepal Health Professional Council to be harmonized with the revised STPs, so that midlevel providers can legally prescribe the essential NCD, mental health and emergency medicines that the package assigns to their level.

With evolving health needs and disease burden, the types and number of health workers required by the health system may change. A data driven assessment of population health needs and health workforce requirements could support systematic workforce planning and recruitment. A major reason for persistent gaps is that sanctioned positions are not filled through permanent recruitment; relying year after year on contract staff and scholarship bonded professionals contributes to high turnover. Filling sanctioned posts through regular recruitment would give the revised package a more stable workforce.

Continuous professional development

Training and preservice curricula would also need to be aligned with the updated BHSP. A functional Training Management Information System (TMIS) can help to identify needs and ensure that training is equitably distributed and aligned with actual requirements. Strengthening supportive supervision through digital tools for remote monitoring, coupled with leadership training, particularly for provincial and local health workers, can foster accountability and continuous quality improvement and support long term staff retention in underserved areas.

Motivation and retention

Incentive schemes, including financial rewards and career progression opportunities, can encourage rural posting and retention, prioritizing equitable distribution, motivation and competency based performance. Such incentives can also motivate health workers to explore innovative

methods proactively to expand service coverage at the community level.

6.3.5 Health information systems, digital health and data for equity

Updating the information system with new indicators

A reliable health information system is essential for tracking progress, guiding policy and programme decisions, and strengthening accountability across all levels of the health system. The existing HMIS could be expanded to incorporate revised indicators aligned with the updated BHSP, so that prioritized interventions are explicitly reflected in routine reporting. Such indicators would enable systematic monitoring of service coverage across population groups and service delivery platforms, providing a clearer picture of who is being reached and where gaps persist.

Improved measurement of coverage through the HMIS is critical for assessing population level health outcomes, as changes in service use and continuity of care directly influence morbidity, mortality and quality of life, particularly for chronic and preventive services. In addition, linking BHSP specific service coverage data with information on service availability, referral patterns and use could strengthen the system's ability to monitor financial protection, including identifying services that reduce OOP expenditure and those for which households remain exposed to financial risk. Regular data use workshops and feedback mechanisms could be promoted to support local governments and health facilities in interpreting HMIS data and using them for evidence based planning, resource allocation and performance improvement, helping to reinforce a culture of data driven decision making within Nepal's federal health system.

Rollout of an electronic medical record system

Rolling out a nationwide electronic medical record (EMR) platform integrated with Nepal's HMIS, with patient linked digital records that track treatment history, could be key to improving efficiency. It would also provide greater flexibility in analysing data from an equity perspective, including disparities related to gender, caste, geography and socioeconomic status. This could help to identify inequities and support targeted resource allocation and the design of equity sensitive interventions under Nepal's federal system and the BHSP, particularly for marginalized populations.

This is also important as the disease burden is increasingly dominated by NCDs that require repeated care. A functional EMR can help to streamline follow up visits through automated appointment scheduling and follow up messages, and medication adherence reminders by SMS or mobile applications, reducing loss to follow up.

Developing an adaptive, learning and resilient health system

Like health systems worldwide, and particularly in LMIC settings, Nepal faces recurrent shocks from earthquakes, floods, epidemics and climate variability. This necessitates a learning and adaptive health system that is able to respond to surges in health care needs while maintaining the delivery of BHS. This requires a strong data system and real time intelligence to facilitate continuous assessment of changing population health needs and climate vulnerabilities, and

strong preparedness tailored to the vulnerabilities of federal Nepal.

6.3.6 Accountability and demand side readiness

Engaging communities in identifying local health priorities, planning services and monitoring health facility performance helps to ensure that health services are responsive to local needs and challenges. Strengthening social accountability mechanisms, such as public hearings, social audits and citizen charters, can help to improve the health system continuously and build trust.

Many communities still face sociocultural barriers, including gender norms, superstitious beliefs, stigma and lack of awareness, which limit the use of services such as maternal health, family planning, nutrition and immunization. Addressing these barriers requires culturally sensitive health education, community engagement through FCHVs, and collaboration with local leaders, teachers and religious figures. Engaging civil society organizations and local institutions can further support outreach, advocacy and behaviour change initiatives, helping to create an enabling environment for increased service use and improved public health.

6.3.7 Monitoring, evaluation and supervision

Monitoring implementation fidelity and overall system performance, with feedback loops for policy and programme adjustment, would help to ensure that the revised BHSP is delivered as intended. Regular review of routine data, monitoring reports and evaluation findings at federal, provincial and local levels, together with joint monitoring visits and knowledge sharing across levels of government, could help to identify good practices and implementation challenges. Monitoring and evaluation arrangements are described in Chapter 7.

6.4 Preparing the health system to sustain basic health services during emergencies

6.4.1 Outbreaks, disasters and basic health services

Nepal regularly faces health emergencies, including disease outbreaks, such as seasonal outbreaks in different parts and ecological zones of the country, and disasters such as earthquakes, floods and landslides, which damage health facilities, disrupt services and create surges in health needs. Large pandemics are also more frequent than commonly assumed: an event with the mortality level of COVID19 is estimated to have an annual probability of 2–3%, occurring on average once every 33 to 50 years.[69] Experience from the COVID-19 pandemic in Nepal and other LMICs showed that essential care was largely deferred during peak surges, and disruptions to routine services such as immunization and tuberculosis programmes led to additional deaths in several settings.[69] For the revised BHSP, preparedness is therefore not a separate agenda: the ability to maintain basic health services during an outbreak is itself a core element of preparedness. Although much of the evidence summarized in this section comes from experience with outbreaks, the same principles, including continuity plans, surge plans, dual use capacity and advance financing, apply equally to disasters and the health emergencies that follow them (see also Section 6.3.5).

6.4.2 Keeping basic health services running

Rather than responding to emergencies only after they occur, health systems

could move towards an "Always On" approach, in which the capabilities that deliver routine services are also those used to prevent, detect and respond to outbreaks.[69] For Nepal, this suggests building preparedness into the platforms that deliver the revised BHSP rather than into parallel structures. Capacities with dual use value, such as laboratory networks and essential diagnostics, oxygen supply, basic clinical care, surveillance and the health workforce, serve day to day needs and can be scaled up during surges (Section 6.3.3). The shortages of medical oxygen during the COVID-19 pandemic showed the importance of resilient oxygen supply systems, and sustaining the investments made during the pandemic could strengthen both routine care and preparedness.

Several relatively low cost measures could help BHS facilities and local governments to maintain essential services during outbreaks and other emergencies:

- **Essential service continuity plans**, identifying the BHS interventions to be protected during surges, how services could be reorganized (for example, through telemedicine, outreach or alternative delivery points) and how supplies of key commodities would be maintained;
- **Clinical care surge plans,** with clear escalation protocols and roles for each level of care, linked to the referral system (Section 6.3.2);
- **Early detection and notification** through routine health information and surveillance systems, for which timeliness targets such as "7-1-7" (detecting a suspected outbreak within seven days, notifying public health authorities within one day and completing an early response within a further seven days) could provide a practical benchmark; and
- **Advance financing arrangements**, such as contingency funds with clear and objective triggers for release, so that resources can reach local governments and facilities quickly at the onset of an outbreak or disaster without lengthy approval processes.[69]

6.4.3 Directions for wider preparedness

Beyond basic health services, preparedness for future outbreaks and other health emergencies would require action across sectors, which lies largely outside the scope of this report. Areas that Nepal could consider in its wider preparedness planning include:[69]

- A One Health approach, with intersectoral coordination and data sharing across human, animal and environmental health to detect emerging pathogens earlier, together with enforcement of laboratory biosafety standards;
- Supply security for medical countermeasures, including rapid procurement processes, stockpiles of key commodities, expedited regulatory review in emergencies and, over time, local manufacturing capacity for selected products (Section 6.3.3); and
- Public health and social measures that are guided by evidence and minimize disruption to education and livelihoods, including in school mitigation measures in place of prolonged school closures.

6.5 Roadmap: responsibilities and sequencing

Table 32 brings the main implementation actions of this chapter

and Chapter 5 together in one roadmap. For each action it names the lead institution, the role of the other levels of government, the prerequisite that must be in place first, the timing and a milestone against which progress can be checked. Near term actions are those needed to adopt the revised package and begin Group 1; medium and long term actions build the systems that sustain it. The leads named are indicative and would be confirmed through the implementation guidelines (Section 6.2).

Table 32: Roadmap for implementing the revised BHSP: responsibilities, prerequisites, timing and milestones

Action	Lead	Role of other levels	Prerequisite	Timing	Milestone
Adopt the revised BHSP by amending the PHSR	MoHFS (Curative Service Division, PPRD)	Provinces and local levels consulted; Council of Ministers approves	Legal review and financial concurrence by the relevant ministries	Short term (FY 2084/85)	Revised PHSR published in the Nepal Gazette
Align budgets with the package	MoHFS (PPRD) with the MoF	Provinces and local levels plan within revised conditional grant guidelines	Costing of Group 1; budget codes linked to interventions	Short term	Conditional grant guidelines with budget lines for the package; BHS share of the health budget at or above its four year average
Update STPs, referral guidelines and the National List of Essential Medicines	DoHS (Curative Service Division and programme divisions)	Provincial health directorates disseminate; facilities apply	Revised package adopted	Short to medium term	Updated STPs and essential medicines list issued
Assess facility readiness by platform and close priority gaps	DoHS with provincial health directorates	Local governments for BHS centres and basic hospitals	Minimum Service Standards tools; NHFR and HIIS data	Short term, then yearly	Share of BHS facilities meeting readiness standards for Group 1
Secure medicines and supplies for Group 1	DoHS logistics and provincial logistics units	Local governments procure within guidelines	Updated essential medicines list; e-LMIS reporting	Short to medium term	Availability of tracer medicines at BHS facilities
Fill sanctioned posts; plan the workforce; harmonize scopes of practice	MoHFS with professional councils	Provincial and local governments recruit and deploy	Staffing assessment by platform	Medium term	Vacancy rate at BHS facilities; scopes of practice aligned with the STPs
Strengthen referral, stabilization and transport	Provincial ministries of health	Local governments; federal hospitals	Updated referral guidelines	Medium term	Completed referrals for selected emergency conditions

Action	Lead	Role of other levels	Prerequisite	Timing	Milestone
Align monitoring indicators with the package	DoHS (Curative Service Division) with the HMIS team	Local governments report through HMIS	Indicator set defined, including effective coverage tracers	Short term	Revised BHSMS indicator set in use
Establish the support structure and continuous priority setting	MoHFS (PPRD) and DoHS technical team	Provinces contribute feasibility appraisals	Mandate and staffing of the two teams	Medium term	Yearly review of the package by the decision authority
Phase in Group 2 and build the HTA mechanism	MoHFS decision authority	Provinces and local levels consulted	Fiscal space; updated evidence	Medium to long term	Group 2 pathways financed; HTA mechanism established

Note: Short term: FY 2084/85 to 2085/86; medium term: FY 2086/87 to 2087/88; long term: beyond 2030, as in Table 30. DoHS: Department of Health Services; HTA: health technology assessment; MoF: Ministry of Finance; PPRD: Policy, Planning and Research Division.

7

Monitoring And Evaluation Of The Basic Health Services Package

7 Monitoring And Evaluation Of The Basic Health Services Package

Monitoring and evaluation (M&E) are core functions for implementing the revised BHSP. They make it possible to track whether the prioritized interventions are being delivered as intended, across service readiness, delivery, coverage, quality and continuity of care, and to assess how the revised package influences resource allocation, financial protection, equity and progress towards UHC. The main emphasis of this chapter is on regular monitoring through reliable routine sources of data, complemented by periodic surveys and evaluation. As with Chapter 6, the arrangements described here are indicative and are intended to inform the detailed design of M&E for the revised package.

7.1 Building on existing monitoring arrangements

Monitoring of the revised BHSP could build on the existing Basic Health Services Monitoring System (BHSMS), developed by the Curative Service Division of the DoHS in 2022 as a monitoring framework with a guideline and an online dashboard, which tracks 102 indicators across the nine service areas of the current package.[70] The BHSMS provides a structured framework for monitoring the availability, access, use and quality of basic health services across federal, provincial and local levels, drawing on routine health information systems, periodic surveys and facility level monitoring.

The BHSMS draws on, and is integrated with, routine health information systems, including the HMIS, the electronic Logistics Management Information System (e-LMIS), the National Health Workforce Registry (NHWR), the National Health Facility Registry (NHFR), the Health Infrastructure Information System (HIIS), the TMIS, the Financial Management Information System (FMIS), the Planning, Logistics and Management Information System for Health Services (PLAMAHS) and the Ayurveda Health Management Information System (AHMIS), together with the Minimum Service Standards (Figure 22). These provide a strong institutional foundation. The changes needed for the revised BHSP could therefore be made progressively, building on the existing guidelines and systems rather than creating parallel ones, and in line with national M&E standards and federal reporting arrangements.

7.2 Aligning indicators with the revised package

The priority setting exercise has produced a clearly defined list of prioritized interventions, each with a specified delivery platform (Chapter 4). This provides a concrete basis for deciding what should be monitored, where services are delivered and at what level of coverage. Implementation of the revised BHSP may therefore require revisiting elements of the current monitoring framework, including the selection and definition of indicators, reporting formats and the analytical use of data, so that the prioritized interventions are adequately captured (see also Section 6.3.5).

Indicators could be defined for each cluster of prioritized interventions and, where relevant, by delivery platform, and integrated into routine HMIS reporting tools. Where a single indicator can track several

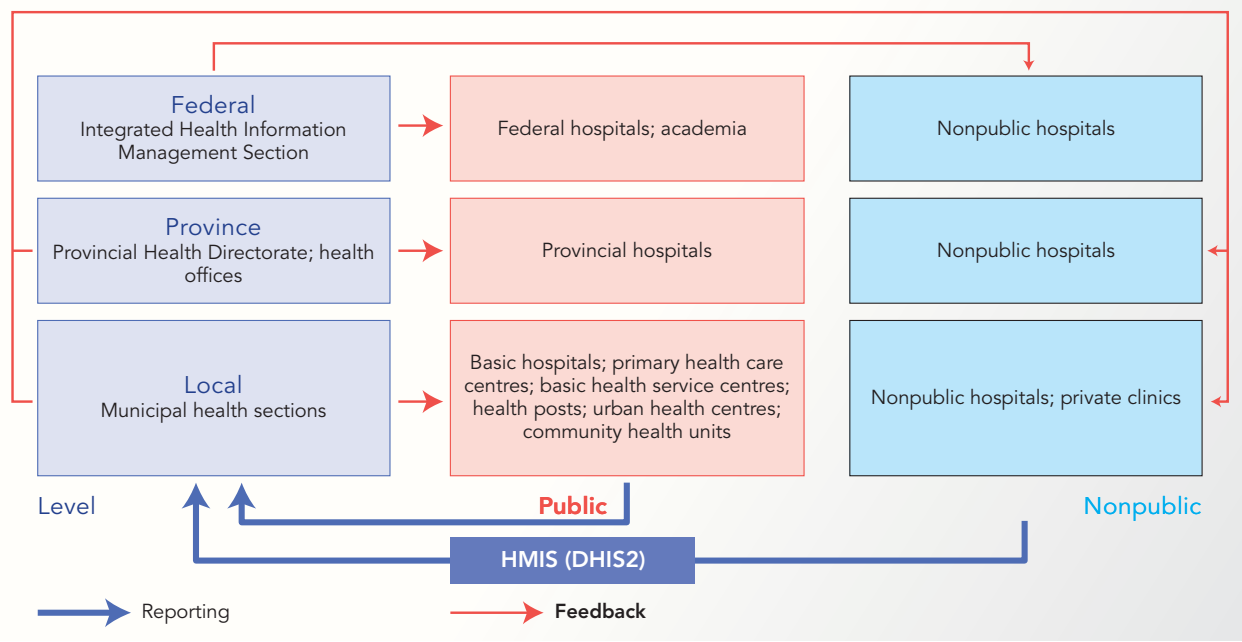


Figure 22: Integrated health management information system

related interventions, as is often the case within programmes, this could help to keep the reporting burden on health facilities manageable.

The exercise also provides a ready starting point for baselines and targets. For each clinical intervention, baseline coverage and target coverage for 2031 were established in the analysis for this exercise (Section 3.5.3). These could serve as initial baselines and targets for monitoring the revised package and be refined as routine data improve.

Routine HMIS indicators mostly count service contacts or crude use, such as the number of people diagnosed with hypertension or the number of antenatal visits, rather than effective coverage, such as the proportion of treated patients whose blood pressure or blood glucose is controlled, or the proportion of births at which the signal functions of quality care are delivered. A core set of effective coverage tracer indicators could therefore be added to the BHSMS for selected Group 1 interventions, drawing on facility records and EMR where available and validated through surveys. Denominators for coverage indicators should be the same populations in need as those used in the costing (Section 3.4.3), so that monitoring baselines are comparable with the targets set in this exercise.

To track equity, indicators could be disaggregated in line with the equity dimensions used in prioritization (Section 3.5.2), including by province and local level, rural or urban setting and population group, where data allow. Because the value of routine data depends on their quality, regular data quality assessment and feedback to reporting facilities would be an important part of the system.

7.3 Regular monitoring through routine information systems

Regular monitoring through routine information systems is the main mechanism for tracking implementation of the revised BHSP, as these systems provide data at frequent intervals and across all levels of government. Table 33 outlines, for illustration, the main monitoring domains and the routine sources that could inform them. The specific indicators would be defined by the MoHFS through the BHSMS.

Table 33: Illustrative monitoring domains, routine data sources and complementary sources for the revised BHSP

Domain	What could be tracked	Main routine sources	Complementary sources needed
Facility readiness	Availability of infrastructure, equipment and diagnostics against the requirements of each delivery platform	NHFR, HIIS, Minimum Service Standards assessments	Nepal Health Facility Survey for service readiness and quality
Health workforce	Staffing at BHS delivery platforms; training aligned with the revised package	NHWR, TMIS	Vacancy data from provincial and local governments
Medicines and supplies	Availability and stockouts of the medicines and commodities required for prioritized interventions	e-LMIS	Nepal Health Facility Survey for tracer medicines available on the day of the visit
Service delivery and coverage	Use and coverage of prioritized interventions, by cluster and delivery platform	HMIS	Population denominators from census projections; NDHS and STEPS for population and effective coverage
Continuity of care and referral	Follow up for chronic conditions; referrals between levels of care	HMIS; EMR where available	Record reviews for control of chronic conditions and completed referrals
Ayurveda and Alternative Medicine	Use of prioritized Ayurveda and Alternative Medicine services	AHMIS	Studies of use, outcomes and safety
Health Promotion	Delivery of prioritized Health Promotion interventions	NHEICC programme reporting	STEPS and other surveys of risk factors and behaviour
Planning, budgeting and expenditure	Budget allocation and spending on BHS, by programme budget code and tier of government	PLAMAHS, FMIS	National Health Accounts and NLSS for total spending and out of pocket payments

Note: Routine sources count services and inputs; population coverage, quality, outcomes and financial protection need the complementary sources.

For Health Promotion, routine programme reporting by NHEICC could provide a starting point. Given the nature of promotive interventions, whose effects often operate indirectly and over the long term, further mechanisms suited to the Nepalese context could be identified and developed over time.

Routine data could be reviewed regularly at local, provincial and federal levels through existing review meetings and planning cycles and summarized for national review processes such as the national joint annual review (Section 6.2). Regular feedback from federal and provincial levels to local governments and health facilities could help to ensure that monitoring results lead to action where gaps are identified.

7.4 Periodic surveys and evaluation

Routine monitoring could be complemented by periodic national surveys and targeted studies that provide population level evidence and help to validate routine data. These

include the Nepal Demographic and Health Survey (NDHS), the STEPS survey of NCD risk factors, the National Mental Health Survey, the Micronutrient Survey, the Nepal Health Facility Survey and the Nepal Living Standards Survey (NLSS). Together, these sources can help to assess effective coverage, quality, equity and financial protection, including out of pocket spending on health, which routine systems do not capture well.

In addition, periodic evaluation of the revised BHSP could assess whether the package is being implemented as intended and whether it is achieving its objectives in terms of coverage, equity and financial protection. Evaluations could draw on routine data, survey findings and, where needed, targeted studies, and could be timed to inform the review and updating of the package.

7.5 Using monitoring results to review the package

Monitoring is useful only if its results inform decisions. Findings from routine monitoring, surveys and evaluation could feed into the operationalization support structure described in Section 6.2.1, helping the DoHS technical team and the Health Economics and Analytics Team to identify interventions whose coverage is lagging, delivery platforms facing constraints and areas where implementation details need to be refined. Routine coverage and cost data could also be used to update the FairChoices analysis for Nepal (Section 6.2.2), so that future rounds of priority setting draw on better local evidence. Financial and service data disaggregated by province, ecological zone and local level could also show how the cost of delivering the package varies across settings, providing an input to the contextualized costing proposed for future rounds (Section 8.2). In this way, M&E could support the periodic review and adjustment of the package in line with evolving population health needs, system capacity and fiscal space.

Different kinds of evidence call for different responses, by different actors. Routine corrective action, such as restoring stock, filling a post or reorganizing outreach when coverage lags, rests with local governments and health facilities, supported by provincial health directorates and DoHS programme divisions, and can be taken within the year. Periodic technical reassessment of an intervention, for example when its costs, coverage or evidence of effectiveness change, is a task for the DoHS technical team and the Health Economics and Analytics Team, which would bring proposals to the decision authority. Formal revision of the BHSP, adding, deferring or removing services, requires a decision by the decision authority and amendment of the PHSR (Section 5.1). Changes in service use observed in routine data also do not by themselves show the effect of the revised package; attributing changes to the package would need evaluation designs with comparison over time or across areas (Section 7.4).

8

Challenges And Limitations

8 Challenges And Limitations

8.1 Challenges

Shifting the conventional health system decision making process towards a more explicit and systematic approach to priority setting was welcomed by the Ministry; however, the transition proved to be time consuming and demanding. The process required gradual changes in existing practices and perspectives among stakeholders, and the scope for prioritization was perceived to be constrained by existing national rules and regulations. Each step also took longer than anticipated, particularly building the database of candidate interventions and mapping it against existing policy, programme and regulatory documents. Changes in staff within divisions and centres during the exercise required new members to be briefed on the process; although this cost some time, momentum could be maintained by keeping incoming staff informed.

Contextualizing the proposed interventions within Nepal's health system also posed challenges. The suggested packaging of services and delivery platforms did not always align well with current health system structures and service delivery modalities. The presence of multiple schemes and benefits has resulted in different forms of benefit packages, adding complexity to efforts to harmonize and prioritize interventions within a coherent health benefits framework.

Limited availability of local data was another key challenge. Reliable estimates of intervention unit costs were often lacking, and baseline coverage data were not available for many interventions, particularly those not tracked through routine information systems or national surveys. Even when data were available, access was frequently constrained by fragmented storage systems and formats that were not readily compatible with the analytical requirements of the exercise, requiring additional time for retrieval, cleaning and adaptation.

8.2 Limitations

- **Evidence on effectiveness:** cost effectiveness could be estimated for 81 of the 204 clinical interventions, those that could be linked to an intervention with effectiveness evidence in the FairChoices database. For the other clinical interventions, effectiveness evidence suitable for modelling was not available in this round, so they were prioritized using their estimated budget impact together with the qualitative criteria, and their cost effectiveness remains to be assessed as evidence becomes available (Section 3.5.3). Evidence on effectiveness, coverage and the population in need was also not available for Ayurveda and Alternative Medicine interventions, and the effectiveness of Health Promotion interventions is often context specific; cost effectiveness could therefore not be estimated for these two categories, which were prioritized through deliberation (Section 3.5.3).

- **Baseline coverage:** where routine or survey data were not available, baseline coverage was estimated from programme information and expert consultation, and target coverage was set through discussion and expert judgement, in line with national goals. Estimates of health gains and costs of scale

up depend on these values and may change as better coverage data become available.

- **Cost data:** unit costs were estimated using a normative, ingredient based approach rather than facility based micro costing (Section 3.4). They reflect the resources expected to be used under standard care rather than observed resource use, and they rely on expert judgement where treatment protocols were silent and on standard assumptions such as a 15 minute visit time. They include 10% wastage on medicines and consumables, a 10% overhead on health worker time and a 5% contingency on other inputs but exclude equipment and referral costs. Costs of Ayurveda and Alternative Medicine interventions were based almost entirely on in country expert judgement, and Health Promotion interventions were not costed in this round, so the budget impact estimates do not cover the full package. Programme specific wastage rates, such as those recorded for vaccines under the National Immunization Programme and for tuberculosis and HIV commodities, could replace the uniform 10% in future rounds.

- **Local variation in costs:** unit costs were estimated as national averages and do not reflect differences in the cost of delivering services across Nepal. Costs are likely to be higher in mountain and remote hill areas, where transport and distribution costs are higher, facilities serve smaller and more dispersed populations, outreach takes more staff time and additional incentives may be needed to retain staff, and they may also differ between urban and rural municipalities. The resource requirements in Chapters 4 and 5 may therefore understate the cost of reaching target coverage in remote areas.

- **Modelling assumptions:** a constant marginal cost was assumed as coverage increases, although costs generally rise as services are extended to harder to reach populations. Unit costs are at 2025 prices, while cost effectiveness ratios are expressed in US dollars at 2024 prices, the price base of FairChoices, and compared with GDP per capita for 2024, the latest year available; the demographic and epidemiological inputs of FairChoices also refer to 2024, and the population in need is held constant over the projection period. For the 21 pathways that match a FairChoices intervention only in part, and for interventions with components that lie outside the Nepal pathways, such as insulin treatment in the management of type 2 diabetes, the ratios credit the health gain of the full FairChoices intervention while counting only the cost of what the Nepal pathway delivers and are therefore optimistic. This matters most for type 2 diabetes, whose ratio fell below half of GDP per capita once the insulin component was given no cost, so that it was included in the package by rule rather than through deliberation (Section 3.5.3).

- Threshold and influence of assumptions: the inclusion line of half of GDP per capita is a reference point rather than an estimate of the health forgone when resources are moved from other services; estimates of these opportunity costs for low and middle income countries generally fall well below one times GDP per capita,[51,52] so some pathways with ratios close to the inclusion line may not be good

value against Nepal's opportunity cost. The assumptions most likely to change the ranking are the treatment of partial matches, whose ratios are optimistic, and the baseline and target coverage set by expert judgement. Those most likely to change the resource requirement are the target coverage, the constant marginal cost and the use of national average unit costs, which together tend to understate the cost of reaching remote populations. Severity weights were used only in the preliminary estimates that informed deliberation, and the final ratios are unweighted (Section 3.5.2). A formal sensitivity analysis of these assumptions is a priority for the next round.

- **Scope and timing of deliberation:** provincial deliberations were held in three of the seven provinces with purposively selected participants, so their findings are not nationally representative, and the provincial burden estimates in Section 2.1.5 reflect age and sex structure rather than measured differences in risk. Further provincial workshops could not be held owing to the national situation in September 2025; by that stage, however, findings across the three provinces had largely converged (Section 4.3.1), suggesting that the main feasibility considerations had been captured. The deliberations took place while the quantitative analysis was being progressively refined and drew on preliminary estimates that applied the default unit costs in the FairChoices database. With locally estimated unit costs, the ratios and the ranking changed, so the outcomes of the deliberations were carried forward as an input to the final selection rather than repeated on the final estimates (Section 3.5.3). At the federal level, structured deliberation in these rounds was confined to a buffer zone of fixed width around the cutoff. In the final selection, interventions at or above half of GDP per capita and those without a cost effectiveness estimate were placed in priority groups through consensus with national level stakeholders, informed by their budget impact, and reviewed at a single national validation meeting, rather than through a further round of deliberation supported by the convergence index. The margin of 5% above the envelope used to size the package is an indicative level, not a budget commitment.

- **Intervention definitions and delivery platforms:** many interventions were initially imprecisely defined, and their scope was specified through consultation with the relevant divisions, centres and experts, so interpretations may vary. Some interventions also span several delivery platforms (for example, normal delivery at basic health facilities with birthing centres, whereas caesarean section requires higher level services), which complicates linking interventions, costs and effectiveness to a single platform.

- Most of these limitations reflect the evidence and data available for a first systematic round of priority setting for the BHSP. Many can be reduced in future rounds as local evidence on coverage, costs and effectiveness improves and as the process is extended, including through broader deliberation at provincial, local and federal levels, as part of the continuous priority setting process described in Section 6.2.2.

Future rounds could also take account of local variation in costs. Adjustment factors by ecological zone, remoteness and type of facility could be derived from provincial and local procurement prices, transport and distribution costs and staffing norms, and applied to the national unit costs. In addition, a few important interventions in the revised BHSP could be selected for implementation research in a small number of palikas representing different ecological and socioeconomic settings, combining facility based micro costing and time and motion studies with the monitoring of coverage and quality. The results would show how far local costs differ from the national estimates and why, provide local evidence on effectiveness and feasibility, and inform both the allocation of conditional grants to local levels (Section 5.6) and the next round of priority setting (Section 6.2.2). Such studies would improve estimates of resource use, costs and feasibility. Evidence on the effectiveness of interventions without a FairChoices counterpart, and of Ayurveda and Alternative Medicine and Health Promotion interventions, would require outcome evaluations with suitable comparison groups or systematic reviews of existing trials.

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Annexes

Annex 1: Burden of disease by province

The table consolidates the subnational estimates summarized in Section 2.1.5 for all seven provinces. Panel A gives summary indicators and Panel B the DALY rate by cause, for both sexes combined, in 2023.

Table 34: Burden of disease by province, 2023

Indicator	Koshi	Madhesh	Bagmati	Gandaki	Lumbini	Karnali	Sudurpashchim	Nepal
A. Summary indicators								
Population (thousand)	5,284.8	6,512.7	6,514.9	2,626.8	5,455.9	1,798.5	2,870.3	31,063.9
Deaths (number)	36,782	27,666	41,643	18,871	32,119	7,692	15,187	179,960
Deaths per 100,000 population	696.0	424.8	639.2	718.4	588.7	427.7	529.1	579.3
DALYs (thousand)	1,866.9	1,467.5	2,159.4	962.7	1,688.3	408.0	796.6	9,349.4
DALYs per 100,000 population	35,327.5	22,532.5	33,144.8	36,647.9	30,945.8	22,686.3	27,755.4	30,097.5
Probability of premature death before age 70 (%)	32.2	22.4	26.0	30.2	30.1	22.7	26.6	–
Share of deaths: CMNN (%)	16.6	20.2	21.4	17.4	21.9	22.4	21.1	19.9
Share of deaths: NCDs (%)	75.4	64.4	71.4	74.3	67.7	65.3	67.9	70.2
Share of deaths: injuries (%)	8.0	15.4	7.2	8.3	10.4	12.4	10.9	9.8
Share of DALYs: CMNN (%)	23.2	27.0	29.3	24.2	29.5	29.9	28.5	27.2
Share of DALYs: NCDs (%)	66.9	54.6	61.9	65.5	57.9	55.4	58.3	60.8
Share of DALYs: injuries (%)	9.9	18.3	8.8	10.3	12.6	14.8	13.2	12.0
B. DALYs per 100,000 population by cause								
Communicable, maternal, neonatal and nutritional diseases	8,200.2	6,090.7	9,702.3	8,864.5	9,127.3	6,777.7	7,913.0	8,183.0
Enteric infections	621.5	461.6	735.3	671.8	691.7	513.7	599.7	620.2
HIV/AIDS and sexually transmitted infections	210.4	156.3	248.9	227.4	234.2	173.9	203.0	209.9

Indicator	Koshi	Madhesh	Bagmati	Gandaki	Lumbini	Karnali	Sudurpashchim	Nepal
Maternal and neonatal disorders	2,997.3	2,226.3	3,546.4	3,240.1	3,336.2	2,477.4	2,892.4	2,991.1
Neglected tropical diseases and malaria	311.6	231.5	368.7	336.9	346.8	257.6	300.7	311.0
Nutritional deficiencies	914.0	678.9	1,081.5	988.1	1,017.4	755.5	882.0	912.1
Other infectious diseases	892.8	663.2	1,056.4	965.2	993.8	737.9	861.6	891.0
Respiratory infections and tuberculosis	2,252.5	1,673.1	2,665.2	2,435.0	2,507.2	1,861.8	2,173.7	2,247.8
Noncommunicable diseases	23,616.7	12,309.5	20,522.7	24,016.9	17,931.5	12,561.8	16,177.3	18,304.9
Cardiovascular diseases	5,652.3	2,946.1	4,911.8	5,748.1	4,291.6	3,006.5	3,871.8	4,381.0
Chronic respiratory diseases	2,953.5	1,539.4	2,566.6	3,003.6	2,242.5	1,571.0	2,023.1	2,289.2
Diabetes and kidney diseases	1,930.0	1,005.9	1,677.1	1,962.7	1,465.4	1,026.5	1,322.0	1,495.9
Digestive diseases	1,794.4	935.3	1,559.3	1,824.8	1,362.4	954.5	1,229.2	1,390.8
Mental disorders	2,372.6	1,236.6	2,061.7	2,412.8	1,801.4	1,262.0	1,625.2	1,838.9
Musculoskeletal disorders	2,698.9	1,406.7	2,345.3	2,744.6	2,049.2	1,435.6	1,848.7	2,091.9
Neoplasms	2,258.7	1,177.3	1,962.8	2,297.0	1,715.0	1,201.4	1,547.2	1,750.7
Neurological disorders	1,538.6	801.9	1,337.0	1,564.6	1,168.2	818.4	1,053.9	1,192.5
Other noncommunicable diseases	1,747.1	910.6	1,518.2	1,776.7	1,326.5	929.3	1,196.7	1,354.1
Skin and subcutaneous diseases	401.6	209.3	349.0	408.4	304.9	213.6	275.1	311.2
Substance use disorders	269.1	140.3	233.9	273.7	204.4	143.2	184.4	208.6
Injuries	3,510.6	4,132.2	2,919.7	3,766.5	3,887.0	3,346.9	3,665.1	3,609.5
Self harm and interpersonal violence	1,002.3	1,179.8	833.6	1,075.3	1,109.7	955.5	1,046.4	1,030.5
Transport injuries	604.1	711.1	502.4	648.2	668.9	575.9	630.7	621.1
Unintentional injuries	1,904.2	2,241.4	1,583.7	2,043.0	2,108.4	1,815.4	1,988.0	1,957.9

Note: Estimates were derived by applying national GBD 2023 age and sex specific rates to the population of each province, so differences between provinces reflect their age and sex structure (Section 2.1.5). Population is the provincial population used in the estimates (deaths divided by the mortality rate). Probability of premature death is the modelled probability of death before age 70 reported in the provincial estimates; a national value was not computed. Nepal values are the sum of the provinces. CMNN: communicable, maternal, neonatal and nutritional diseases; DALYs: disability adjusted life years; NCDs: noncommunicable diseases. Source: Global Burden of Disease Study 2023.[19]

Annex 2: Governance structure

The priority setting exercise leading to this report was governed by a Steering Committee and a TWC, with several thematic groups as relevant and required under the broader governance structure. The Department of Ayurveda and Alternative Medicine, the Department of Drug Administration, all other divisions and centres within the Department of Health Services and sections within those divisions and centres, and representatives of health development partners, academia and civil society organizations participated in the TWC and thematic meetings throughout the process.

Table 35: Composition of the Steering Committee

Position	Designation
Advisor	Secretary, MoHFS
Chair	Additional Secretary, MoHFS
Member	Director General, Department of Health Services
Member	Chief, Policy, Planning and Research Division, MoHFS
Member	Chief, Quality Standard and Regulation Division, MoHFS
Member	Director, National Health Training Centre, DoHS, MoHFS
Member Secretary	Chief, Public Health Coordination and Information Technology Division, MoHFS
Permanent invitees	
Permanent invitee	Director General, Department of Drug Administration
Permanent invitee	Director General, Department of Ayurveda and Alternative Medicine
Permanent invitee	Director, Curative Service Division, DoHS, MoHFS
Permanent invitee	Director, Epidemiology and Disease Control Division, DoHS, MoHFS
Permanent invitee	Director, Family Welfare Division, DoHS, MoHFS

Table 36: Composition of the Technical Working Committee

Position	Designation
Chair	Chief, Public Health Coordination and Information Technology Division, MoHFS
Member	Chief, Quality Standard and Regulation Section, Quality Standard and Regulation Division, MoHFS
Member	Chief, Curative Service, Education and Research Section, Policy, Planning and Research Division, MoHFS
Member	Chief, Policy and Planning Section (Health Financing), Policy, Planning and Research Division, MoHFS
Member Secretary	Chief, Provincial and Local Health Coordination Section, Public Health Coordination and Information Technology Division, MoHFS
Invitees	
Invitee	Division and section chiefs from all other relevant programme divisions, academia, research institutions and development partners

Annex 3: List of interventions with costs, cost effectiveness and final priority group

Table 37: Interventions with delivery platform, costs, cost effectiveness, stream and final priority group

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
1	BCG Vaccination	BHSC	597,891	72	95	143	81.4	Below 0.5	A	1
2	MR Vaccination	BHSC	597,891	71	95	550	312.6	Below 0.5	A	1
3	Pentavalent Vaccination (DPT-HepB-Hib)	BHSC	597,891	71	95	815	463.0	Below 0.5	A	1
4	Pneumococcal Vaccination	BHSC	597,891	71	95	1,974	1,121.3	Below 0.5	A	1
5	Rotavirus Vaccination	BHSC	597,891	71	95	937	532.0	Below 0.5	A	1
6	Birth dose of OPV	BHSC	597,891	71	90	169	91.1	No FairChoices match	D	1
7	Booster dose of Pentavalent vaccine	BHSC	597,891	70	90	308	166.0	No FairChoices match	D	1
8	Birth dose of Hep B Vaccination	BHSC	597,891	71	90	130	69.7	No FairChoices match	D	1
9	Human papillomavirus (HPV) immunization	School/BHSC	1,654,939	18	95	930	1,462.0	Below 0.5	A	1
10	Polio Vaccination (Oral | IPV)	BHSC	597,891	71	95	224	127.4	No health gain modelled	B	1
11	Japanese encephalitis Vaccination	BHSC	597,891	70	95	173	98.2	No FairChoices match	D	1

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
12	Typhoid Vaccination	BHSC	597,891	71	95	410	233.0	No FairChoices match	D	1
13	Combined Oral Contraceptives	BHSC	461,051	55	65	591	177.0	No health gain modelled	B	1
14	DMPA	BHSC	873,346	55	65	703	398.9	No health gain modelled	B	1
15	Condom	BHSC	461,051	55	65	477	142.9	No health gain modelled	B	1
16	DMPA s/c	BHSC	79,493	55	70	963	53.6	No health gain modelled	B	1
17	Male Sterilization	Basic Hospital	8,801	32	45	4,228	16.7	No health gain modelled	B	1
18	Female sterilization: Mini laparotomy	Basic Hospital	68,666	32	45	5,391	166.6	No health gain modelled	B	1
19	Provision of emergency contraceptive pills	BHSC	1,177,559	19	30	753	266.1	No health gain modelled	B	1
20	IUCD	BHSC	133,193	55	70	6	6.1	No health gain modelled	B	1
21	Implant	BHSC	624,981	55	70	89	195.2	No health gain modelled	B	1
22	Counselling for family planning [CoFP]	BHSC	1,780,000	63	80	330	469.9	No FairChoices match	D	1
23	Prevention of Mother-to-Child Transmission of HIV (PMTCT)	Basic Hospital	658,058	82	95	2,635	1,647.2	No FairChoices match	D	1

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
24	Management of complication of abortion	Basic Hospital	6,460	66	85	10,526	57.8	1 or more	C	2
25	Essential ANC interventions	BHSC	693,850	88	95	5,804	3,825.4	1 or more	C	1
26	Management of pregnancy-related thyroid disorder (hypothyroidism)	BHSC	90,201	33	53	165	7.9	1 or more	C	2
27	Essential Newborn care	BHSC	597,891	63	90	609	327.5	Below 0.5	A	1
28	Management of common problem in newborns (Annex 3.1)	BHSC (BEONC)/ BHSC/Basic Hospital	Varies	Varies	Varies	Varies	317.5	See Annex 3.1	A	1
29	Management of neonatal sepsis	Basic Hospital	38,524	72	90	2,079	72.1	Below 0.5	A	1
30	Management of pneumonia	Basic Hospital	20,744	69	90	1,792	33.5	Below 0.5	A	1
31	Management of acute malnutrition among children under 5	BHSC	297,865	19	39	9,520	1,097.4	Below 0.5	A	1
32	Medical abortion	BHSC	94,247	79	85	676	54.2	No health gain modelled	B	1
33	Surgical abortion	Basic Hospital	36,109	83	85	6,459	198.2	No health gain modelled	B	1
34	Identification, first-line support and referral for survivors of GBV	Community/ BHSC	426,012	3	23	503	49.3	1 or more (partial)	C	1

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
35	Safe delivery (Normal labour)	BHSC (BEONC)	490,271	52	90	3,572	1,575.9	Below 0.5	A	1
36	Screening and identification and referral for infertility	BHSC	713,329	6.2	26	495	92.5	No FairChoices match	D	3
37	Identification and referral of obstetric fistula	BHSC	490,271	18	38	822	152.7	No FairChoices match	D	2
38	Screening and referral of breast cancer	BHSC	2,927,598	5	27	660	512.0	No health gain modelled	D	2
39	Identification and management of pelvic organ prolapse	BHSC	526,860	4.8	25	990	129.4	No FairChoices match	D	2
40	Screening of cervical cancer and management of pre-invasive cervical cancer	Basic Hospital	1,300,580	29	49	1,069	678.3	Below 0.5	A	1
41	Management of anaemia among children	BHSC	500,320	12	32	1,012	161.5	No FairChoices match	D	1
42	Folic acid supplementation during pre-conception and first trimester	BHSC	693,850	45	60	648	269.8	No FairChoices match	D	2
43	Routine postpartum care	Community/ BHSC	597,891	58	90	1,218	655.6	No FairChoices match	D	1

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
44	Management of common problems in postpartum (Annex 3.1)	BHSC/Basic Hospital	Varies	Varies	Varies	Varies	93.5	See Annex 3.1	D	1 and 2
45	Multi-micronutrient powder supplementation to children of age 6 to 23 months	Community/ BHSC	896,836	82	85	422	321.6	No FairChoices match	D	1
46	Obstetric first aid and referral (excluding management of complication of abortion) (Annex 3.1)	BHSC (BEONC)/ Basic Hospital/ BHSC	Varies	Varies	Varies	Varies	482.6	See Annex 3.1	A, D	1
47	Iron and folic acid supplementation for adolescent girls	School/BHSC	603,498	81	85	65	33.4	No FairChoices match	D	1
48	Preventive Chemotherapy for Soil-Transmitted Helminths (Deworming)	Community/ BHSC	4,678,526	78	90	55	231.0	No FairChoices match	D	1
49	Nutritional assessment adult in OPD and counselling (BMI measurement)	BHSC	6,836,467	20	40	274	748.6	No FairChoices match	D	2
50	Biannual Vit A distribution	Community/ BHSC	5,037,192	81	95	55	262.7	No FairChoices match	D	1

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
51	Vitamin A deficiency treatment	Basic Hospital	60,000	21	61	118	4.3	No FairChoices match	D	2
52	Growth Monitoring and Promotion of Under 2 years	BHSC	1,372,483	75	88	333	402.0	No FairChoices match	D	1
53	Screening of HIV among TB patients	BHSC	68,000	57	77	509	26.7	No FairChoices match	D	1
54	Community home-based care for PLHIV	Community/ BHSC	32,847	80	90	2,968	87.7	Below 0.5 (partial)	A	1
55	Syndromic management of STI (GUD and Urethral Discharge)	BHSC	150,000	6.3	26	573	22.6	Below 0.5	A	1
56	Management of Urinary Tract Infection	BHSC	2,027,148	21	42	551	463.4	0.5 to 1	C	2
57	Management of typhoid and paratyphoid	Basic Hospital	268,138	80	90	1,248	301.2	Below 0.5	A	1
58	Management of acute diarrhoea in adults	BHSC	4,239,572	11	31	588	770.4	Below 0.5	A	1
59	Management of acute diarrhoea and dehydration in children	BHSC	6,410,721	10	30	684	1,333.4	Below 0.5	A	1
60	Management of extensively drug-resistant TB (children)	DR-TB treatment centres and subcentres	7	0	40	194,330	0.5	No FairChoices match	D	1

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
61	Management of acute lower respiratory infections in adults (Acute Bronchitis)	BHSC	459,810	25	65	982	292.6	Below 0.5	A	1
62	Management of acute lower respiratory infections in adults (Pneumonia)	BHSC	306,540	55	90	865	238.5	Below 0.5	A	1
63	Management of acute lower respiratory infections in children (bronchiolitis)	BHSC	676,622	83	85	1,406	808.7	Below 0.5	A	1
64	Management of acute lower respiratory infections in children (pneumonia)	BHSC	150,455	46	86	2,288	296.1	Below 0.5	A	1
65	Management of measles	BHSC	500	84	100	448	0.2	Below 0.5	A	1
66	Management of multidrug-resistant TB (children)	DR-TB treatment centres and subcentres	232	0.4	40	66,841	6.3	No FairChoices match	D	1
67	Management of pre-XDR TB (adult)	DR-TB treatment centres and subcentres	122	75	90	519,111	57.0	No FairChoices match	D	1

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
68	Management of pre-XDR TB (children)	DR-TB treatment centres and subcentres	13	20	60	126,160	1.0	No FairChoices match	D	1
69	Management of Hydatidosis/ Echinococcosis	Basic Hospital	1,146	50	75	1,738	1.5	Below 0.5 (partial)	A	1
70	Identification and Management of Trachoma	BHSC	8,388	79	100	372	3.1	Below 0.5	A	1
71	Management of leptospirosis	Basic Hospital	38	45	70	1,220	0.0	No FairChoices match	D	2
72	Management of uncomplicated malaria in children (P vivax/P ovale)	BHSC	169	73	95	661	0.1	Below 0.5	A	1
73	Management of uncomplicated malaria in children (P falciparum/ mixed infection)	BHSC	53	74	95	672	0.0	Below 0.5	A	1
74	Management of rubella	Basic Hospital	105	21	100	386	0.0	No FairChoices match	D	2
75	Diagnosis and referral for treatment of Visceral Leishmaniasis	Basic Hospital	284	78	86	564	0.1	Below 0.5 (partial)	A	1

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
76	Emergency management and referral of acute encephalitis syndrome	Basic Hospital	14,942	3.5	44	1,349	8.8	No FairChoices match	D	2
77	Management of Salmonellosis	BHSC	724	92	95	324	0.2	No FairChoices match	D	2
78	Emergency management and referral of meningitis	Basic Hospital	15,090	12	52	1,227	9.6	No FairChoices match	D	2
79	TB preventive therapy	BHSC	82,371	6	46	555	21.0	No health gain modelled	B	1
80	Management of Leprosy	BHSC	2,941	86	90	2,409	6.4	No FairChoices match	D	1
81	Prevention of Disability and Self care in Leprosy	BHSC	2,941	74	90	7,833	20.7	No FairChoices match	D	3
82	Management of influenza-like-illness (Seasonal influenza)	BHSC	175,592	81	85	394	58.8	No FairChoices match	D	2
83	Supportive care for acute hepatitis E	Basic Hospital	21,007	2.8	23	2,372	11.5	No FairChoices match	D	2
84	Screening of hepatitis C for PWID	Community/ local level	44,350	6	37	1,290	21.2	0.5 to 1 (partial)	C	1
85	Management of Cestode (Taeniasis)	BHSC	41,452	34	50	210	4.4	No FairChoices match	D	2

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
86	Management of Pelvic Inflammatory Disease (PID)	Basic Hospital	553,935	36	70	1,215	471.2	Below 0.5	A	1
87	Management of Toxoplasmosis	Basic Hospital	96,600	20	40	572	22.1	No FairChoices match	D	2
88	Management of scrub typhus	Basic Hospital	42,490	71	75	1,069	34.1	No FairChoices match	D	2
89	Supportive care for acute hepatitis A	Basic Hospital	48,299	3.5	23	2,524	28.0	Below 0.5	A	1
90	Management of chickenpox in adult	BHSC	4,518	81	90	1,038	4.2	No FairChoices match	D	2
91	Management of Cellulitis	BHSC	58,610	81	85	641	31.9	No FairChoices match	D	2
92	Management of Abscess	BHSC	348,649	81	85	1,723	510.6	No FairChoices match	D	2
93	Management of Boils and Furunculosis	BHSC	265,399	81	85	780	176.0	No FairChoices match	D	2
94	Management (self-care) of Lymphoedema due to lymphatic filariasis (including management of disabling morbidity)	Community/ BHSC	30,000	10	50	2,154	32.3	No FairChoices match	D	2

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
95	Symptomatic management of dengue	BHSC	28,438	80	85	845	20.4	No FairChoices match	D	2
96	Management of herpes zoster	BHSC	30,284	80	85	802	20.6	No FairChoices match	D	2
97	Management of mumps	BHSC	18,937	51	90	175	3.0	No FairChoices match	D	2
98	Post-exposure Prophylaxis for leprosy	BHSC	2,941	74	90	2,742	7.3	No FairChoices match	D	2
99	Management of chickenpox in children	BHSC	6,436	81	100	443	2.9	No FairChoices match	D	2
100	Management of acute pharyngitis and acute tonsillitis in children	BHSC	881,106	43	63	607	334.7	1 or more	C	1
101	Active case finding and linkage to care for TB	Community/ local level	26,899	80	85	1,979	45.2	No FairChoices match	D	2
102	Management of pediculosis	BHSC	495,000	1.2	21	259	27.2	No FairChoices match	D	2
103	Management of oral mucosal disease: oral ulceration, stomatitis	BHSC	1,882,996	7.9	28	381	200.1	No FairChoices match	D	2
104	Management of brucellosis	Basic Hospital	2,916	25	45	1,653	2.2	No FairChoices match	D	2

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
105	Management of otomycosis	BHSC	70,121	21	41	476	13.8	No FairChoices match	D	2
106	Management of upper respiratory tract infections in children (acute rhinitis, sinusitis)	BHSC	1,577,162	80	85	390	522.2	No FairChoices match	D	1
107	Management of Acute Suppurative Otitis Media (ASOM)	BHSC	792,969	36	75	764	454.1	No FairChoices match	D	2
108	Management of the soil-transmitted helminthiases	BHSC	1,686,432	28	48	755	613.4	No FairChoices match	D	2
109	Management of Stye	BHSC	119,000	21	41	323	15.6	No FairChoices match	D	2
110	Management of Blepharitis	BHSC	160,000	19	39	451	28.2	No FairChoices match	D	2
111	Management of scabies	BHSC	465,976	74	85	327	129.7	No FairChoices match	D	2
112	Management of drug susceptible pulmonary TB (children)	BHSC	9,283	62	75	14,086	98.1	No FairChoices match	D	1

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
113	Management of upper respiratory tract infections in adults (acute rhinitis, sinusitis)	BHSC	1,619,445	79	85	375	515.7	No FairChoices match	D	1
114	Mass Drug Administration for Lymphatic Filariasis	Community/ BHSC	1,555,735	79	90	347	486.4	No FairChoices match	D	1
115	Management of drug susceptible extrapulmonary TB (adult)	BHSC	1,021	61	75	24,700	18.9	Below 0.5	A	1
116	Management of extensively drug-resistant TB (adult)	DR-TB treatment centres and subcentres	52	32	75	685,854	26.7	1 or more	C	1
117	Management of drug susceptible pulmonary TB (adult)	BHSC	46,044	55	75	35,074	1,211.2	Below 0.5	A	1
118	Management of uncomplicated malaria in adult (P vivax/P ovale)	BHSC	958	73	95	678	0.6	Below 0.5	A	1
119	Management of uncomplicated malaria in adult (P falciparum/ mixed infection)	BHSC	301	73	95	686	0.2	Below 0.5	A	1
120	Management of acute Pharyngitis and tonsillitis in adult	BHSC	968,052	43	63	467	283.2	No FairChoices match	D	2

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
121	Management of ringworm, other bacterial and fungal skin infections	BHSC	4,190,118	19	39	886	1,429.1	No FairChoices match	D	1
122	Management of Conjunctivitis	BHSC	1,166,583	45	65	319	241.9	No FairChoices match	D	2
123	Management of drug susceptible extrapulmonary TB (children)	BHSC	1,524	80	85	32,080	41.6	No FairChoices match	D	1
124	Management of multidrug-resistant TB (adult)	DR-TB treatment centres and subcentres	2,668	20	60	129,281	207.0	Below 0.5	A	1
125	Management of Bronchial Asthma in Children	BHSC	133,369	13	33	1,044	45.5	No FairChoices match	D	2
126	Emergency management of acute exacerbation of asthma	Basic Hospital	64,545	62	80	1,065	55.0	Below 0.5	A	1
127	Longitudinal management of diabetes mellitus type 1	Basic Hospital	14,010	40	60	9,566	80.4	Below 0.5	A	1
128	Longitudinal management of diabetes mellitus type 2	BHSC	1,748,609	25	45	3,058	2,427.3	Below 0.5	A	1

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
129	Management of phimosis	Basic Hospital	29,211	41	50	4,718	68.9	No FairChoices match	D	2
130	Self-care and participation, including bowel and bladder care	BHSC	179,960	15	35	9,870	621.7	No FairChoices match	D	3
131	Screening of colorectal cancer	Basic Hospital	4,015	25	45	385	0.7	No health gain modelled	B	1
132	Primary prevention with absolute CVD risk	BHSC	3,378,859	31	50	353	595.9	Below 0.5	A	1
133	Emergency management and referral of stroke	Basic Hospital	43,747	33	53	2,849	65.6	Below 0.5 (partial)	A	1
134	Longitudinal management of CVD	BHSC	459,890	17	37	7,600	1,303.8	Below 0.5	A	1
135	Emergency management and referral of ischaemic heart disease	Basic Hospital	73,077	50	70	2,264	115.8	Below 0.5 (partial)	A	1
136	Longitudinal management of asthma	BHSC	645,451	13	33	2,097	442.6	1 or more	C	2
137	Longitudinal management of COPD	BHSC	764,311	24	44	3,178	1,073.4	Below 0.5	A	1

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
138	Emergency management of acute exacerbation of COPD	Basic Hospital	382,156	33	53	3,006	612.2	Below 0.5	A	1
139	Initial management of gastrointestinal bleeding and referral	Basic Hospital	29,165	48	68	5,680	112.0	Below 0.5 (partial)	A	1
140	Dental care (caries, tooth extraction, drainage of dental abscess)	Basic Hospital	2,916,458	16	36	1,699	1,759.3	Below 0.5	A	1
141	Brief intervention on alcohol cessation and control	BHSC	350,574	4.2	30	385	40.5	Below 0.5	A	1
142	Primary palliative care	Basic Hospital	30,900	8	28	5,221	45.2	No health gain modelled	B	1
143	Management of sudden hearing loss	BHSC	6,213	5	20	3,147	3.9	No FairChoices match	D	2
144	Emergency management of septic arthritis and referral	Basic Hospital	621	59	74	3,453	1.6	No FairChoices match	D	3
145	Screening and referral of oral cancer	BHSC	7,448	25	45	780	2.6	Below 0.5 (partial)	A	1
146	Screening and management of Sickle cell and thalassaemia	BHSC	1,892	98	100	10,742	20.3	Below 0.5 (partial)	A	1

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
147	Screening and referral of congenital heart disease	BHSC	5,381	49	69	220	0.8	No FairChoices match	D	2
148	Symptomatic Management of gouty arthritis and referral	Basic Hospital	121,479	78	85	1,395	144.1	No FairChoices match	D	2
149	Secondary Prevention of RHD	Basic Hospital	290,435	13	33	2,349	223.1	Below 0.5	A	1
150	Cerumen (ear wax) removal	Basic Hospital	161,933	79	85	708	97.5	No FairChoices match	D	2
151	Symptomatic management of rheumatoid arthritis and referral	Basic Hospital	119,542	80	85	2,342	237.9	No FairChoices match	D	2
152	Management of Acid peptic disease	BHSC	4,053,165	49	59	443	1,064.0	No FairChoices match	D	2
153	Identification and referral of acute kidney injury	Basic Hospital	373,305	15	35	710	92.8	Below 0.5 (partial)	A	1
154	Basic physiotherapy management of neurological condition: stroke, spinal cord injury, cerebral palsy, parkinsonism disorder	BHSC	304,644	20	35	3,016	321.6	Below 0.5 (partial)	A	1

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
155	Basic support for Activity of Daily Living for neuro/ developmental/ cognitive condition: Autism spectrum disorder, Down syndrome, intellectual disability (Caregiver training)	BHSC	427,803	15	30	1,037	133.1	No FairChoices match	D	2
156	Early identification and referral for childhood developmental disorders	BHSC	427,803	20	35	644	96.5	No FairChoices match	D	2
157	Management of Chalazion	BHSC	166,238	19	80	554	73.7	No FairChoices match	D	2
158	Management of otitis externa	BHSC	280,485	21	70	729	143.0	No FairChoices match	D	2
159	Identification and Referral of Cataract	BHSC	716,064	77	80	244	139.8	Below 0.5 (partial)	A	1
160	Management of Acute Laryngitis	Basic Hospital	517,209	4.2	65	476	159.9	No FairChoices match	D	2
161	Management of Periodontal Disease: gingivitis, glossitis, periodontitis, periodontal abscess	Basic Hospital	3,765,992	6.9	27	1,216	1,227.8	No FairChoices match	D	3

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
162	Basic respiratory and cardiovascular rehabilitation Services: Breathing and airway clearance techniques, oedema management, education on lifestyle modification	BHSC	1,051,074	20	35	2,706	995.6	Below 0.5 (partial)	A	1
163	Basic assessment of vision and provision of reading glasses	BHSC	1,944,531	24	44	424	364.2	Below 0.5	A	1
164	Initial management of eczema and referral	Basic Hospital	675,574	70	75	383	194.1	No FairChoices match	D	2
165	Management of low back pain (acute | chronic)	BHSC	2,982,373	43	53	1,166	1,853.1	No FairChoices match	D	3
166	Initial management of Neck Abscess	Basic Hospital	2,916	68	80	2,584	6.0	No FairChoices match	D	2
167	Basic assessment of hearing function and referral	BHSC	1,604,052	10	30	513	247.1	No FairChoices match	D	2
168	Basic rehabilitation service: Basic Assistive Products related to mobility	BHSC	323,878	4.4	24	1,392	110.0	No FairChoices match	D	2

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
169	Assessment and management of signs and symptoms related to Noncommunicable Diseases	BHSC	3,823,649	45	65	424	1,055.0	No FairChoices match	D	2
170	Interventions for improving physical activity: Brief advice as part of routine care in OPD	BHSC	6,836,467	20	50	275	940.0	No FairChoices match	D	2
171	Management of joint pain	BHSC	3,581,971	57	72	443	1,141.8	No FairChoices match	D	3
172	Tobacco cessation counselling (psychosocial education and psychosocial support)	BHSC	7,020,367	31	50	385	1,351.4	Below 0.5 (partial)	A	1
173	Fracture and dislocation in trauma patients	Basic Hospital	280,000	57	77	3,270	701.2	No FairChoices match	D	2
174	Management of anxiety disorder (GAD, Panic Disorder)	BHSC	323,407	35	55	2,938	525.5	1 or more	C	2
175	Initial management of PTSD	Basic Hospital	83,114	9.8	30	1,955	48.4	Below 0.5	A	1
176	Management of depression	BHSC	294,673	27	47	2,972	410.7	Below 0.5	A	1

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
177	Initial management of suicide and self-harm and referral	Basic Hospital	72,587	4.8	25	1,966	35.4	Below 0.5	A	1
178	Basic management of migraine and referral	Basic Hospital	1,256,302	4.7	25	2,506	777.6	1 or more	C	2
179	Basic management of epilepsy	Basic Hospital	123,766	23	40	7,437	368.2	Below 0.5	A	1
180	Management of Substance Use Disorder	BHSC	437,632	6.6	27	3,014	350.9	0.5 to 1 (partial)	C	2
181	Identification and referral of child and adolescent mental and behavioural disorder	BHSC	155,447	3.6	24	825	30.3	Below 0.5 (partial)	A	1
182	Management of Dissociative (conversion) disorder	BHSC	224,922	6.2	26	330	19.4	No FairChoices match	D	3
183	Initial management of bipolar disorders	Basic Hospital	112,625	19	39	28,276	1,238.8	0.5 to 1	C	3
184	Initial management of psychotic disorders	Basic Hospital	105,240	21	41	4,214	181.4	Below 0.5	A	1
185	Basic management of dementia (Alzheimer's and others)	Basic Hospital	91,140	21	41	1,637	61.2	Below 0.5	A	1

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186	Management of wounds and suturing	BHSC	119,073	55	75	1,981	176.9	Below 0.5	A	3
187	Primary management of common poisoning	Basic Hospital	17,002	23	70	4,720	56.2	Below 0.5 (partial)	A	1
188	Management of Foreign Body (Nose, Throat)	Basic Hospital	42,009	56	65	414	11.3	No FairChoices match	D	2
189	Primary management of snake bites	Basic Hospital	16,448	81	85	1,485	20.8	No FairChoices match	D	2
190	Management of Foreign Body (Eye)	BHSC	14,468	82	85	383	4.7	No FairChoices match	D	2
191	Primary management of burn	BHSC	150,499	51	71	1,602	171.2	Below 0.5 (partial)	A	1
192	Primary management of shock and referral	Basic Hospital	56,000	68	80	3,031	135.8	No FairChoices match	D	2
193	Primary management of Unconscious Patient and referral	Basic Hospital	56,000	68	80	1,802	80.7	No FairChoices match	D	2
194	Primary management of Convulsions and referral	BHSC	56,000	74	80	1,025	45.9	No FairChoices match	D	2
195	Primary Trauma Care (PTC)	Basic Hospital	726,530	68	80	3,785	2,199.9	Below 0.5 (partial)	A	1

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196	Primary management of drowning and referral	Basic Hospital	28,842	81	85	1,516	37.2	No FairChoices match	D	2
197	Primary management of shortness of breath and referral	BHSC	168,000	65	80	2,920	392.4	No FairChoices match	D	2
198	Primary management of insect bites (wasp, bee) and referral	BHSC	56,000	71	80	316	14.2	No FairChoices match	D	2
199	Primary management of acute retention of urine and referral	Basic Hospital	28,000	83	85	1,902	45.3	No FairChoices match	D	2
200	Primary management of chest pain and referral	Basic Hospital	280,000	18	80	1,186	265.6	No FairChoices match	D	2
201	Primary management of oral and maxillofacial injury	BHSC	278,330	45	60	1,426	238.2	No FairChoices match	D	3
202	Management of Foreign Body (Ear)	Basic Hospital	50,883	80	85	434	18.8	No FairChoices match	D	2
203	Case Management of dog bites and other animal bites	BHSC	299,610	22	85	1,270	323.5	No FairChoices match	D	2

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204	Management of Nose bleeding (Epistaxis)	BHSC	901,657	1.1	75	805	544.4	No FairChoices match	D	2
205	Management of influenza like illness with Ayurveda	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–
206	Management of gastritis with Ayurveda	Nagarik Aarogya Kendra	–	–	–	–	–	Not estimated	–	–
207	Management of grahini (IBS) with Ayurveda	Ayurveda Health Service Centre (General Ayur Hospital), equivalent to Basic Hospital	–	–	–	–	–	Not estimated	–	–
208	Management of UTI with Ayurveda	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–
209	Treatment of Renal calculi with Ayurveda	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–
210	Basic management of sinusitis, pharyngitis and tonsillitis with Ayurveda and referral	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–
211	Initial management of Leucorrhoea with Ayurveda and referral	Nagarik Aarogya Kendra	–	–	–	–	–	Not estimated	–	–

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212	Management of PCOD with Ayurveda	Ayurveda Health Service Centre (General Ayur Hospital), equivalent to Basic Hospital	–	–	–	–	–	Not estimated	–	–
213	Management of Dysmenorrhoea with Ayurveda	Nagarik Aarogya Kendra	–	–	–	–	–	Not estimated	–	–
214	Initial management of menorrhagia with Ayurveda and referral	Ayurveda Health Service Centre (General Ayur Hospital), equivalent to Basic Hospital	–	–	–	–	–	Not estimated	–	–
215	Management of OA with Ayurveda	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–
216	Management of Gouty Arthritis and RA with Ayurveda	Ayurveda Health Service Centre (General Ayur Hospital), equivalent to Basic Hospital	–	–	–	–	–	Not estimated	–	–
217	Complementary management of common NCDs (type II DM, Primary HTN) with Ayurveda	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–

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218	Basic management of nonbleeding haemorrhoids (1,2 degree), anal fissure etc with Ayurveda	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–
219	Lactational promotion with shatavari supplementation for breastfeeding mothers	Nagarik Aarogya Kendra	–	–	–	–	–	Not estimated	–	–
220	Abhyanga for fibromyalgia (Ayurveda)	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–
221	Swedana therapy for inflammatory condition of joints (tennis elbow, golf elbow) (Ayurveda)	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–
222	Shirodhara for anxiety, insomnia, mild depression, mild hypertension etc	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–
223	Nasya for headache, migraine	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–
224	Supportive management for general debility with Rasayan Therapy	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–

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225	Medhya rasayana for enhancing memory power	Nagarik Aarogya Kendra	–	–	–	–	–	Not estimated	–	–
226	Swarna Bindu Prashan (1 yr to 5 yrs Children) overall growth and development, immunity and also to overcome developmental delays.	Ayurveda Health Service Centre (General Ayur Hospital), equivalent to Basic Hospital	–	–	–	–	–	Not estimated	–	–
227	Yoga for health promotion	Nagarik Aarogya Kendra	–	–	–	–	–	Not estimated	–	–
228	Therapeutic Yoga for mechanical back pain, stress management, PTSD, migraine, tension headache, sinusitis, insomnia, hyperacidity	Ayurveda Health Service Centre (General Ayur Hospital), equivalent to Basic Hospital	–	–	–	–	–	Not estimated	–	–
229	Complementary yoga therapy for common NCDs (Type II DM, HTN)	Ayurveda Health Service Centre (General Ayur Hospital), equivalent to Basic Hospital	–	–	–	–	–	Not estimated	–	–

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
230	Complementary management of common NCDs (Type II DM, HTN, Dyslipidaemia) through naturopathy	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–
231	Conservative management of vertebral disorders (Cervical spondylosis, lumbar spondylosis) with naturopathy	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–
232	Conservative management of common arthritis (OA, RA) with naturopathy	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–
233	Management of musculoskeletal pain (low back pain, neck pain) with naturopathy	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–
234	Management of GI symptoms and disorders (Chronic gastritis, Constipation, Hyperacidity) with naturopathy	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
235	Supportive management of common psychological disorders (anxiety, depression) with naturopathy	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–
236	Management of Obesity through naturopathy	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–
237	Conservative management of prolapsed intervertebral disc (PIVD) with naturopathy	Ayurveda Health Service Centre (General Ayur Hospital), equivalent to Basic Hospital	–	–	–	–	–	Not estimated	–	–
238	Conservative management of spondylitis, spondylolisthesis with naturopathy	Ayurveda Health Service Centre (General Ayur Hospital), equivalent to Basic Hospital	–	–	–	–	–	Not estimated	–	–
239	Management of IBS with naturopathy	Ayurveda Health Service Centre (General Ayur Hospital), equivalent to Basic Hospital	–	–	–	–	–	Not estimated	–	–

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
240	Management of skin disorders (Psoriasis, Eczema) with naturopathy	Ayurveda Health Service Centre (General Ayur Hospital), equivalent to Basic Hospital	–	–	–	–	–	Not estimated	–	–
241	Management of common headache disorders (migraine, sinusitis) with naturopathy	Ayurveda Health Service Centre (General Ayur Hospital), equivalent to Basic Hospital	–	–	–	–	–	Not estimated	–	–
242	Management of low back pain with acupressure/ cupping	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–
243	Management of cervical spondylosis with acupressure/ cupping	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–
244	Management of OA with acupressure/ cupping	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–
245	Management of frozen shoulder with acupressure/ cupping	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
246	Management of neurological disorders (stroke rehabilitation) with acupuncture	Ayurveda Health Service Centre (General Ayur Hospital), equivalent to Basic Hospital	–	–	–	–	–	Not estimated	–	–
247	Management of neurological problem (facial palsy) with acupuncture	Ayurveda Health Service Centre (General Ayur Hospital), equivalent to Basic Hospital	–	–	–	–	–	Not estimated	–	–
248	Management of neurological problem (trigeminal neuralgia) with acupuncture	Ayurveda Health Service Centre (General Ayur Hospital), equivalent to Basic Hospital	–	–	–	–	–	Not estimated	–	–
249	Management of neurological problem (polyneuropathy) with acupuncture	Ayurveda Health Service Centre (General Ayur Hospital), equivalent to Basic Hospital	–	–	–	–	–	Not estimated	–	–

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
250	Management of migraine, sciatica (radiculopathy) and chronic pain with acupuncture	Ayurveda Health Service Centre (General Ayur Hospital), equivalent to Basic Hospital	–	–	–	–	–	Not estimated	–	–
251	Management of sleep disorder with acupuncture	Ayurveda Health Service Centre (General Ayur Hospital), equivalent to Basic Hospital	–	–	–	–	–	Not estimated	–	–
252	Management of Dysmenorrhoea with acupuncture	Ayurveda Health Service Centre (General Ayur Hospital), equivalent to Basic Hospital	–	–	–	–	–	Not estimated	–	–
253	Management of arthritis with Homeopathy	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–
254	Management of hyperuricaemia with Homeopathy	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–
255	Treatment of respiratory system symptoms (like tonsillitis) with Homeopathy	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
256	Treatment of acidity with Homeopathy	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–
257	Management of skin problems like warts, skin allergy with Homeopathy	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–
258	Management of UTI with Homeopathy	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–
259	Management of Renal Calculi with Homeopathy	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–
260	Basic management of non-bleeding haemorrhoids/ piles (Stage I and II) with Homeopathy	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–
261	Management of Benign prostatic hypertrophy with Homeopathy	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–
262	Complementary management of common NCDs (Type II DM, HTN) through Homeopathy	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–
263	Management of Dysmenorrhoea, leucorrhoea and PCOS with Homeopathy	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
264	Management of delayed developmental milestones like late walking, speaking with Homeopathy.	Ayurvedic Aushadhalaya	–	–	–	–	–	Not estimated	–	–
265	Community engagement and behaviour change communication for malaria, dengue and other NTD/ VBDs prevention	Community	–	–	–	–	–	Not estimated	–	–
266	School-based health education and health promotion	School	–	–	–	–	–	Not estimated	–	–
267	Periodic school-based health Screening for Children	School	–	–	–	–	–	Not estimated	–	–
268	Adolescent NCD risk-factor prevention counselling and messaging (tobacco, alcohol, substances)	Local level	–	–	–	–	–	Not estimated	–	–

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
269	Health communication on communicable and infectious diseases prevention and control (vector-borne, zoonotic and neglected tropical diseases, immunization, Tuberculosis, HIV/AIDS, IEC/BCC materials during outbreaks and health emergencies – 52 diseases)	Local level	–	–	–	–	–	Not estimated	–	–
270	Public awareness campaigns for specific diseases and conditions (NCD screening awareness month, immunization campaigns, World Breastfeeding Week, World AIDS Day, mental health awareness campaigns)	Local level	–	–	–	–	–	Not estimated	–	–

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
271	Epidemic preparedness awareness and communicable disease messaging via media monitoring and social listening (enabling)	Local level	–	–	–	–	–	Not estimated	–	–
272	Advocacy on RMNCHN-related issues (breastmilk substitutes regulation, safe abortion services, child health and routine immunization)	Federal/ provincial/ local level	–	–	–	–	–	Not estimated	–	–
273	Risk Communication and Community Engagement (RCCE) for outbreaks and health emergencies	Local level	–	–	–	–	–	Not estimated	–	–
274	Advocacy on communicable disease prevention and control	Federal/ provincial/ local level	–	–	–	–	–	Not estimated	–	–
275	Advocacy on NCD risk-factor prevention	Federal/ provincial/ local level	–	–	–	–	–	Not estimated	–	–

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
276	Settings-based health promotion (healthy palika, health promoting schools, health promoting hospitals)	Local level	–	–	–	–	–	Not estimated	–	–
277	Warn about the dangers of tobacco: Mass media anti-tobacco campaign	Local level	–	–	–	–	–	Not estimated	–	–
278	Offer to help quit tobacco use – mCessation (digital cessation support)	Local level/ BHSC	–	–	–	–	–	Not estimated	–	–
279	Advocacy to raise taxes on tobacco products	Federal/ provincial/ local level	–	–	–	–	–	Not estimated	–	–
280	Interaction / Group health education for smokers regarding tobacco control	Local level	–	–	–	–	–	Not estimated	–	–
281	Tobacco/alcohol advocacy in provinces with political and local leaders	Provincial/ local level	–	–	–	–	–	Not estimated	–	–
282	Advocacy to raise tax on alcohol	Federal/ provincial/ local level	–	–	–	–	–	Not estimated	–	–

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
283	Public health awareness on NCD and NCD risk factors (hypertension, diabetes, salt/ sodium intake, sugar-sweetened beverages, trans-fat and other NCDs)	Local level	–	–	–	–	–	Not estimated	–	–
284	Public health awareness on violence and injury (acid attack, burns, accidents, injuries)	Local level	–	–	–	–	–	Not estimated	–	–
285	Senior citizen health awareness (including eye and oral health promotion)	Local level	–	–	–	–	–	Not estimated	–	–
286	Organ transplantation awareness communication (service uptake and informed decision-making)	Local level	–	–	–	–	–	Not estimated	–	–
287	Public awareness on nutrition promotion (iodine, vitamin A supplementation and deworming)	Local level	–	–	–	–	–	Not estimated	–	–

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
288	Public awareness on WaSH (personal hygiene, WaSH messaging)	Local level	–	–	–	–	–	Not estimated	–	–
289	Advocacy on environmental health and antimicrobial resistance (AMR)	Federal/ provincial/ local level	–	–	–	–	–	Not estimated	–	–
290	Curriculum and textbook review for age-appropriate health education in schools	Federal/ provincial/ local level	–	–	–	–	–	Not estimated	–	–
291	Food fortification	Community	–	–	–	–	–	Not estimated	–	–
292	Rice fortification with 8 minerals	Federal/ provincial/ local level	–	–	–	–	–	Not estimated	–	–
293	Iodine fortification of salt	Federal/ provincial/ local level	–	–	–	–	–	Not estimated	–	–
294	Wheat flour fortification	Federal/ provincial/ local level	–	–	–	–	–	Not estimated	–	–
295	Community-based GBV awareness and prevention	Community/ local level	–	–	–	–	–	Not estimated	–	–
296	Indoor residual spraying for malaria and v. leishmaniasis prevention (vector control)	District Health Office	–	–	–	–	–	Not estimated	–	–

Count ID	Intervention	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
297	Distribution and promotion of insecticide-treated nets	Local level/ BHSC	–	–	–	–	–	Not estimated	–	–
298	Community interventions for HIV prevention and screening for key populations	Community	–	–	–	–	–	Not estimated	–	–
299	School-based preventive oral health interventions	School	–	–	–	–	–	Not estimated	–	–
300	Basic management and referral of common health problems among school children	School	–	–	–	–	–	Not estimated	–	–

Note: Count IDs number the 300 candidate interventions. Clinical interventions show the population in need, baseline and target coverage, unit cost in NPR at 2025 prices (including a 10% overhead on health worker time and a 5% contingency on other inputs), and annual cost at target in NPR million at 2025 prices, from the final run of 1 November 2026. Cost effectiveness gives the band of the cost per healthy life year gained relative to GDP per capita (US$1,447.7, 2024), below 0.5 times or 0.5 times or more; partial matches are marked, and pathways linked to several FairChoices interventions take the band of their best ranked linked intervention (Section 4.2.3). Stream refers to the four streams of the final selection (Section 3.5.3). Final group: 1, recommended priority package; 2, could be included with additional budget; 3, deferred for now (Section 4.3.3). The condition column records the condition attached to pathways included with conditions, or the reason recorded at validation; none of the conditions lowers target coverage. Count IDs 28, 44 and 46 are bundles of related interventions counted once; their components are costed separately in Annex 3.1. Health Promotion interventions were not costed. Populations in need and targets have not been set for Ayurveda and Alternative Medicine interventions, so their costs are not shown; examples of their unit costs are given in Section 4.2.2. All 60 Ayurveda and Alternative Medicine and all 36 Health Promotion interventions were retained (Section 4.4). BEONC: basic emergency obstetric and newborn care; BHSC: basic health service centre; STP: standard treatment protocol.

Annex 3.1: Components of bundled interventions

Table 38: Components of the bundled interventions in Cluster 2 (RMNCAH-N)

Count ID	Bundled intervention (counted once)	No.	Component intervention (costed separately)	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
28	Management of common problems in newborns	28.1	Birth Asphyxia	BHSC (BEONC)	10,710	75	90	880	8.5	Below 0.5	A	1
28		28.2	Neonatal Convulsion	BHSC	10,568	79	100	971	10.3	Below 0.5	A	1
28		28.3	Hypothermia	BHSC	89,684	5.6	46	1,268	51.9	Below 0.5	A	1
28		28.4	Preterm or Low Birth Weight Newborn	BHSC	119,578	35	75	853	76.9	Below 0.5	A	1
28		28.5	Breastfeeding difficulties/ Problem	BHSC	59,789	60	90	540	29.1	Below 0.5	A	1
28		28.6	Oral Thrush	BHSC	96,509	85	100	155	14.9	Below 0.5	A	1
28		28.7	Pustules	BHSC	59,789	60	100	270	16.2	Below 0.5	A	1
28		28.8	Neonatal Jaundice	Basic Hospital	17,518	31	71	1,721	21.3	Below 0.5	A	1
28		28.9	Neonatal Hypoglycaemia	BHSC	65,768	35	75	715	35.5	Below 0.5	A	1
28		28.10	Neonatal Conjunctivitis	BHSC	29,895	52	90	1,604	43.2	Below 0.5	A	1
28		28.11	Bacterial Infection (local)	BHSC	29,895	52	90	365	9.8	Below 0.5	A	1
	Subtotal								317.5			

Count ID	Bundled intervention (counted once)	No.	Component intervention (costed separately)	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
44	Management of common problems in postpartum	44.1	Management of Common Issues- Breast Issues: Engorgement/ Mastitis	BHSC	59,789	23	63	357	13.4	No FairChoices match	D	2
44		44.2	Management of Common Issues- UTI (difficulty/pain urinating)	BHSC	17,937	58	90	627	10.1	No FairChoices match	D	2
44		44.3	Management of Common Issues- Constipation	BHSC	149,473	58	90	342	46.1	No FairChoices match	D	1
44		44.4	Management of Common Issues- Rh negative mother	Basic Hospital	14,823	30	50	2,095	15.5	No FairChoices match	D	1
44		44.5	Wound Infection (Perineal tear/ Episiotomy/C-section)	BHSC	14,947	10	50	1,122	8.4	No FairChoices match	D	2
	Subtotal								93.5			

Count ID	Bundled intervention (counted once)	No.	Component intervention (costed separately)	Delivery platform	Population in need	Baseline coverage (%)	Target coverage (%)	Unit cost (NPR)	Annual cost at target (NPR million)	Cost effectiveness (× GDP per capita)	Stream	Final group
46	Obstetric first aid and referral (excluding management of complications of abortion)	46.1	Antepartum Haemorrhage (APH)	BHSC (BEONC)	4,286	79	90	2,972	11.5	No FairChoices match	D	1
46		46.2	Mild pre-eclampsia	BHSC (BEONC)	15,545	56	76	984	11.6	No FairChoices match	D	1
46		46.3	Severe pre-eclampsia/ eclampsia	Basic Hospital	6,938	75	90	2,204	13.8	No FairChoices match	D	1
46		46.4	Prolonged/ Obstructed Labour	BHSC (BEONC)	52,000	56	76	1,278	50.3	No FairChoices match	D	1
46		46.5	Postpartum Haemorrhage	BHSC (BEONC)	41,329	56	76	2,206	68.9	Below 0.5 (partial)	A	1
46		46.6	Puerperal Infection	BHSC	14,610	56	76	1,126	12.4	Below 0.5	A	1
46		46.7	Perineal and cervical Injury	BHSC (BEONC)	152,462	57	90	2,290	314.2	No FairChoices match	D	1
	Subtotal								482.6			

Note: Each component is costed as a separate pathway. Early care for newborns in FairChoices covers all eleven newborn components together with essential newborn care, so each takes its band. Values at 2025 prices, from the final run.

Annex 4: Summary from provincial deliberations

Table 39: Comparative summary of province level feasibility appraisal findings

Theme or intervention	Karnali Province	Sudurpashchim Province	Lumbini Province	Narration
Cancer interventions (screening, management)	Not feasible; absent infrastructure and specialists.	Cervical cancer: screening and thermocoagulation partially feasible; advanced management not feasible. Breast cancer: screening only feasible.	All cancer interventions not feasible; strengthening referral to Sushil Koirala Memorial Cancer Hospital recommended.	Unanimous cross province finding. The most advanced position is Sudurpashchim's partial operationalization of cervical cancer screening, pointing to a replicable incremental model.
Advanced cardiac care (ACS, cardiac surgery, stents)	Treatment of ACS not feasible owing to human resource and infrastructure deficits.	Stents and cardiac surgery necessary but not feasible; referral available, yet recovery window routinely exceeded.	ACS not currently feasible but anticipated to be feasible in the near term; RHD and major cardiac events: referral pathway recommended.	All three provinces identify the feasibility gap; Sudurpashchim uniquely flags the time critical recovery window as a clinical limitation of referral based mitigation.
Mental health services (common disorders, inpatient care, OAT)	Advanced dementia management not feasible.	Inpatient mental health care not feasible at provincial level; stigma and demand side barriers highlighted; political commitment needed for GBV related and climate related disorders.	Dementia and PTSD: no STP, insufficient human resources. Anxiety: needed at district level, currently only at provincial hospital. OAT: limited to two provincial hospitals.	Human resource shortages and absent protocols are shared constraints. Sudurpashchim introduces the demand side lens (stigma, GBV, climate change), an important extension of the conventional supply side framing of feasibility.
Burn management and dental services	Not explicitly documented.	Both not feasible owing to human resources and infrastructure; felt need acknowledged.	Burns: not feasible; STP development recommended. Dental: expand below district level through dental hygienists.	Convergent finding between Sudurpashchim and Lumbini. Lumbini goes further with actionable recommendations (STP; task shifting to dental hygienists), offering a model for other provinces.
Specialized surgical care (club foot, hydrocephalus shunt, Wilms tumour, neurosurgery)	Club foot, hydrocephalus shunt, Wilms tumour and oral or facial clefts: all not feasible.	Not explicitly documented.	Club foot (equity lens required), Wilms tumour and neurosurgery: all not feasible at provincial level; referral to national centre recommended.	Karnali and Lumbini independently flag Wilms tumour and club foot, confirming the absence of paediatric surgical oncology capacity across provinces and the need for a nationally coordinated referral pathway.

Theme or intervention	Karnali Province	Sudurpashchim Province	Lumbini Province	Narration
Palliative care	Not documented.	Not feasible despite acknowledged need.	Guidelines in place but infrastructure and technical capacity lacking.	Lumbini's finding that guidelines exist but cannot be implemented shifts the challenge from policy advocacy to implementation science and resource mobilization.
Stroke (acute treatment and rehabilitation)	Stroke rehabilitation not feasible.	Not explicitly documented.	Acute stroke treatment limited to provincial level only.	Together, Karnali and Lumbini reveal a gap across the full stroke continuum, from acute management to rehabilitation, neither of which is adequately addressed at local level.
Cross cutting and intersectoral (emergency care, NCD prevention, adolescent, and disability services)	Emergency care: prehospital triage and stabilization need priority facilitation.	Not explicitly documented.	Emergency care: low BHSP capacity and referral tracking needed. NCD prevention: sugar and sodium taxes and legal compliance required. Adolescent services: stigma as a demand side barrier. Disability: inclusive infrastructure and legal compliance required.	Lumbini provides the most granular Category D assessment, including fiscal policy instruments (sugar and sodium taxes), a finding absent elsewhere. These structural and legislative insights warrant integration into the national EHCP framework.
Systemic: human resources, infrastructure, and referral pathways	Human resource and physical infrastructure gaps underlie all not feasible determinations. Political instability cited as a governance constraint.	Human resource and geographical barriers cited; task shifting proposed as a mitigation strategy. Province differentiated approaches recommended given dispersed population and topography.	Human resource, logistics and legal gaps cut across all categories. Workforce sustainability risk flagged (temporary programme based staff). Tiered delivery model proposed for chronic care.	Human resources for health are the universal binding constraint. Provinces differ in mitigation strategy: Sudurpashchim proposes task shifting; Lumbini recommends tiered, platform specific delivery. Both strategies are evidence based and mutually compatible.

Note: ACS: acute coronary syndrome; BHSP: Basic Health Services Package; GBV: gender based violence; NCD: noncommunicable disease; OAT: opioid agonist treatment; PTSD: posttraumatic stress disorder; RHD: rheumatic heart disease; STP: standard treatment protocol. Intervention names are those used in the provincial deliberations, which were held before the candidate list was finalized, and may differ from those in Annex 3.

Annex 5: Prioritization matrix for Health Promotion interventions

The matrix sets out each of the 36 Health Promotion interventions in Cluster 8, grouped by the themes and tiers of Section 4.4.1. Interventions keep the tier of their theme; the recommended action sets priority within the theme, with fiscal, regulatory and best buy measures ranked first.

Table 40: Intervention level prioritization matrix for Health Promotion (Cluster 8)

ID	Intervention	Main risk or outcome	Linked GBD 2023 burden (thousand DALYs)	Evidence of effect and value for money	Strength	Lead level and platform	AWPB visibility (NPR million a year)	Recommended action
A. Tobacco and alcohol control Tier 1 | weighted score 3.00 | linked burden 1,776 RA								
0325	Advocacy to raise taxes on tobacco products	Tobacco use	1,668 RA: CVD, chronic respiratory, neoplasms	Best buy; Nepal ROI 281:1; health and financial gains largest for the poorest55,58,71	Best buy	Federal: MoHFS and NHEICC with MoF	None identified	Scale up (lead measure)
0323	Mass media campaign on the dangers of tobacco	Initiation and quitting	1,668 RA	Best buy; Nepal ROI 56:1 for awareness campaigns55,58,72	Best buy	Federal and provincial: NHEICC	About 43 (shared with 0327, 0328)	Scale up as sustained campaigns
0324	Digital cessation support for tobacco users (mCessation)	Quitting among users	1,668 RA	Cessation support is a best buy; text messaging raises quit rates (RR 1.54)55,73	Best buy	Federal platform linked to Quitline and PHC	About 4; none in FY 2083/84	Scale up with Quitline
0328	Advocacy to raise taxes on alcohol	Harmful alcohol use	114 RA: alcohol specific causes; part of injuries and cancers	Best buy; excise costs under I$100 per healthy life year55,74	Best buy	Federal: MoHFS with MoF	None identified; regulation lines shared	Scale up (lead measure)
0327	Tobacco and alcohol advocacy with political and local leaders in provinces	Enforcement of existing laws	1,776 RA (subcluster)	Enabling; effect depends on enforcement	Enabling	Provincial and local health offices	About 10	Maintain; link to enforcement
0326	Group health education for smokers on tobacco control	Quitting among users	1,668 RA	Individual cessation measures return about 1:1 in Nepal58	Moderate	Local: health facilities	Within shared lines	Integrate into brief advice at PHC

ID	Intervention	Main risk or outcome	Linked GBD 2023 burden (thousand DALYs)	Evidence of effect and value for money	Strength	Lead level and platform	AWPB visibility (NPR million a year)	Recommended action
0314	Adolescent NCD risk factor counselling and messaging (tobacco, alcohol, substances)	Initiation in adolescents	Linked to A	School programmes give small effects on tobacco use75	Moderate	Local: school health and nursing	Under 1	Integrate into school health (0312)
B. Nutrition and food fortification Tier 1 | weighted score 3.00 | linked burden 1,025 RA								
0337	Food fortification (umbrella)	Micronutrient deficiencies	263 RA: nutritional deficiencies	Fortification lowers anaemia by 34%, goitre by 74% and neural tube defects by 41%76	Strong	Federal: MoHFS with food regulator and industry	Under 1	Protect; mandate standards
0340	Wheat flour fortification	Anaemia, neural tube defects	202 RA iron deficiency; 13 total neural tube defects	Folic acid fortification lowers neural tube defects by 41%76	Strong	Federal: standards with mills	None dedicated	Scale up (mandatory standard)
0339	Iodine fortification of salt	Iodine deficiency	4 total (low after iodization)	Goitre odds 74% lower with fortification76	Strong	Federal: regulation and monitoring	Within 0337	Maintain monitoring
0338	Rice fortification with eight minerals	Iron deficiency	202 RA: dietary iron deficiency	Lowers iron deficiency (RR 0.66); low certainty evidence77	Moderate	Federal and provincial: public food distribution, school meals	None dedicated	Target through public food programmes
0318	Advocacy on RMNCAH and nutrition issues (breastmilk substitutes regulation, safe abortion, child health, routine immunization)	Breastfeeding, newborn and child health	762 RA: maternal and neonatal disorders	Breastfeeding protection, including the BMS code, is a best buy55	Best buy	Federal: Family Welfare Division with regulators	Shared advocacy lines	Focus on BMS Act enforcement

ID	Intervention	Main risk or outcome	Linked GBD 2023 burden (thousand DALYs)	Evidence of effect and value for money	Strength	Lead level and platform	AWPB visibility (NPR million a year)	Recommended action
0333	Public awareness on nutrition (iodine, vitamin A supplementation, deworming)	Micronutrient intake and uptake	1 RA vitamin A deficiency; 60 RA protein energy malnutrition	Vitamin A lowered child mortality by 30% in Nepal; mass deworming shows little effect on growth or haemoglobin78,79	Strong (vitamin A)	Local: FCHVs and mothers' groups	About 2	Integrate into FCHV campaigns
C. NCD risk awareness and healthy ageing Tier 1 | weighted score 2.70 | linked burden 1,421 RA								
0329	Public awareness on NCDs and risk factors (hypertension, diabetes, salt, sugar sweetened beverages, trans fat)	Diet, salt, blood pressure	957 RA CVD; 464 RA diabetes and kidney	Best buy: FCHV lifestyle counselling lowered systolic blood pressure by 4.9 mmHg in Nepal55,80	Best buy	Federal mass media; local FCHV outreach	About 16	Scale up as sustained campaigns
0321	Advocacy on NCD risk factor prevention	Salt, trans fat, sugar and labelling policy	957 RA CVD; 464 RA diabetes and kidney	Enables regulatory best buys: reformulation, labelling and taxation55	Enabling	Federal: MoHFS with MoF and food regulator	About 7 (tied to NCD screening)	Refocus on legislation
0331	Senior citizen health awareness, including eye and oral health	Healthy ageing	141 vision loss, 168 hearing loss, 59 oral disorders (total)	Limited direct evidence	Limited	Local: FCHVs and senior citizen groups	About 3	Integrate into home visits
D. Vector control and HIV prevention for key populations Tier 2 | weighted score 2.30 | linked burden 162 total								
0343	Distribution and promotion of insecticide treated nets	Malaria transmission	0.1 total malaria (near elimination)	Falciparum episodes 42% lower than with untreated nets81	Strong	Local: endemic and receptive areas	Within malaria and commodity lines	Target to foci
0342	Indoor residual spraying for malaria and visceral leishmaniasis	Vector density	0.1 malaria; 1.4 visceral leishmaniasis (total)	Reduces malaria incidence in unstable transmission settings82	Moderate	Provincial and district: outbreak foci	Training only; insecticide under commodity code	Target to foci

ID	Intervention	Main risk or outcome	Linked GBD 2023 burden (thousand DALYs)	Evidence of effect and value for money	Strength	Lead level and platform	AWPB visibility (NPR million a year)	Recommended action
0344	Community HIV prevention and screening for key populations	HIV transmission	65 total: HIV and STIs	WHO recommended prevention package for key populations83	Strong	Local with NGOs at key population sites	About 11 (stigma, prisons, border points)	Target and sustain
E. Communicable disease communication and advocacy Tier 2 | weighted score 2.25 | linked burden 384 total								
0311	Community engagement and behaviour change communication for malaria, dengue and other vector borne diseases	Breeding sites, care seeking	24 dengue; 13 lymphatic filariasis (total)	Community mobilization lowered dengue infection by 29.5%84	Strong	Local: wards and schools in hotspots	About 55 (larval source reduction)	Scale in dengue hotspots
0315	Health communication on communicable diseases (52 diseases, including outbreak IEC)	Awareness across diseases	222 TB; 65 HIV and STIs; 97 NTDs and malaria (total)	Limited direct evidence for generic IEC	Limited	Federal and provincial: NHEICC	About 10	Consolidate into one platform
0320	Advocacy on communicable disease prevention and control	Policy support	As 0315	Limited direct evidence	Limited	Federal: EDCD	None identified	Merge with 0315
F. WASH and environmental health Tier 2 | weighted score 2.15 | linked burden 385 RA								
0334	Public awareness on WASH (personal hygiene and WASH messaging)	Handwashing, safe water	106 RA diarrhoeal diseases; 279 RA LRI	Handwashing promotion lowers diarrhoea by about a quarter; education alone is not significant85	Strong (with soap)	Local: schools and households with WASH sector	No dedicated hygiene line	Combine with soap and WASH services

ID	Intervention	Main risk or outcome	Linked GBD 2023 burden (thousand DALYs)	Evidence of effect and value for money	Strength	Lead level and platform	AWPB visibility (NPR million a year)	Recommended action
0335	Advocacy on environmental health and antimicrobial resistance	Air pollution, AMR	513 RA chronic respiratory; 279 RA LRI	No direct trial evidence; air quality and AMR need regulation	Limited	Federal: MoHFS with environment and agriculture	About 20 (zoonoses and AMR events)	Redesign towards clean air and AMR stewardship
G. School health Tier 2 | weighted score 2.00 | linked burden 78 total								
0345	School based preventive oral health	Dental caries	59 total: oral disorders	Fluoride varnish prevents 43% of caries in permanent teeth86	Strong	Local: school health	None identified	Scale up (fluoride)
0312	School based health education and health promotion	Health literacy, risk behaviour	Entry point for A to C	Small gains in BMI, physical activity and tobacco use75	Moderate	Local: schools with education sector	About 7	Maintain through school nurses
0313	Periodic school based health screening for children	Vision, nutrition, oral health	19 refractions; 59 oral disorders (total)	Limited direct evidence; useful when linked to spectacles and referral	Limited	Local: school nurses	About 8 (eye screening)	Target to vision
0346	Basic management and referral of common health problems among school children	Access to care	Not cause specific	Clinical service; access gains through school nurses	Limited	Local: school health and nursing	About 125 (school health and nursing)	Maintain; classify as clinical
0336	Curriculum and textbook review for age-appropriate health education	Health literacy	Enabling	Enabling and low cost	Enabling	Federal: with Curriculum Development Centre	Minimal	Maintain (periodic)
H. Outbreak risk communication Tier 3 | weighted score 1.95 | linked burden 118 total								
0319	Risk communication and community engagement (RCCE) for outbreaks and health emergencies	Outbreak response	94 COVID-19; 24 dengue (total, 2023)	IHR core capacity; evidence mainly from outbreak experience	Moderate	Federal and provincial: HEOC with EDCD	About 7	Integrate with surveillance

ID	Intervention	Main risk or outcome	Linked GBD 2023 burden (thousand DALYs)	Evidence of effect and value for money	Strength	Lead level and platform	AWPB visibility (NPR million a year)	Recommended action
0317	Epidemic preparedness messaging through media monitoring and social listening	Misinformation	As 0319	Limited direct evidence	Limited	Federal: NHEICC with HEOC	About 1	Integrate with 0319
I. Injury, violence and GBV awareness Tier 3 | weighted score 1.70 | linked burden 470 RA								
0330	Public awareness on violence and injury (acid attacks, burns, road and other injuries)	Injury risk	470 RA (1,082 total): all injuries	Awareness alone is weak; drink driving enforcement is a best buy55	Limited	Multisectoral: transport, police, local level	About 5 (shared)	Redesign towards enforcement
0341	Community based GBV awareness and prevention	Violence against women	42 total: interpersonal violence	Limited evidence for awareness alone	Limited	Local with women and children sector and one stop crisis centres	About 6 (shared)	Target; link to one stop crisis centres
J. Settings based promotion and awareness campaigns Tier 3 | weighted score 1.50 | linked burden Cross cutting								
0322	Settings based health promotion (healthy palika, health promoting schools and hospitals)	Supportive environments	Cross cutting	Moderate for schools; limited for palika and hospitals75	Moderate	Local: palika	About 9	Use as delivery platform
0316	Public awareness campaigns for specific diseases and health days	Awareness	Cross cutting	Limited direct evidence	Limited	All levels	About 11	Consolidate
0332	Organ transplantation awareness (service uptake and informed decision making)	Organ donation	143 total chronic kidney disease; small eligible group	Limited direct evidence	Limited	Federal: transplant coordination unit	About 3	Retain in tier 3; deliver through existing campaigns

Source: GBD 2023;[19] approved annual work plan and budget of the MoHFS, FY 2080/81 to 2083/84; studies as cited in the table.

Annex 6: Cost effectiveness results and link to Nepal interventions

Table 41: Cost per healthy life year gained

Rank	Nepal intervention	Coverage, baseline to target (%)	HLYs gained	Incremental cost, 5 years (US$ million)	US$ per HLY	× GDP per capita	HAAD (years)	Equity rank	Stream
1	Identification and Management of Trachoma	79 to 100	53,625	0.01	0.1	<0.01	70.1*	1	A
2	Diagnosis and referral for treatment of Visceral Leishmaniasis	78 to 86	743	<0.01	0.5	<0.01	55.3	3	A
3	Screening and referral of oral cancer	25 to 45	14,657	0.01	0.5	<0.01	59.2	2	A
4	Primary management of burn	51 to 71	1,834	<0.01	0.6	<0.01	65.3	5	A
5	Management of typhoid and paratyphoid in adults	80 to 90	12,489	0.01	0.6	<0.01	60.6	4	A
6	Management of neonatal sepsis; Management of pneumonia	71 to 90	196,742	0.13	0.7	<0.01	20.9	6	A
7	Identification and referral of acute kidney injury (acute kidney disease)	15 to 35	21,102	0.02	1.1	<0.01	65.5	7	A
8	Management of typhoid and paratyphoid in children	80 to 90	30,157	0.06	1.9	<0.01	53.8	8	A
9	Management of Hydatidosis/ Echinococcosis	50 to 75	885	<0.01	3.1	<0.01	66.3	9	A
10	Identification and Referral of Cataract	77 to 80	8,518	0.05	6.1	<0.01	71.4*	10	A
11	Management of measles	84 to 100	18,654	0.19	10	0.01	53.4	11	A
12	Emergency management and referral of ischaemic heart disease	50 to 70	22,139	0.24	11	0.01	66.9	13	A
13	Identification and referral of acute kidney injury (end stage kidney failure)	15 to 35	1,344	0.02	14	0.01	56.0	12	A

Rank	Nepal intervention	Coverage, baseline to target (%)	HLYs gained	Incremental cost, 5 years (US$ million)	US$ per HLY	× GDP per capita	HAAD (years)	Equity rank	Stream
14	Basic assessment of vision and provision of reading glasses (children)	24 to 44	851	0.02	20	0.01	65.0*	15	A
15	Management of acute lower respiratory infections in children (bronchiolitis); Management of acute lower respiratory infections in children (pneumonia)	76 to 85	56,780	1.24	22	0.02	48.3	16	A
16	Management of acute diarrhoea and dehydration in children	10 to 30	18,930	0.47	25	0.02	63.1	17	A
17	Pentavalent Vaccination (DPT-HepB-Hib)	71 to 95	113,870	2.91	26	0.02	12.2	18	A
18	Essential newborn care; management of common problems in newborns (eleven components)	63 to 90	123,063	3.17	26	0.02	55.7	19	A
19	Basic assessment of vision and provision of reading glasses (adults)	24 to 44	17,274	0.55	32	0.02	69.4*	20	A
20	Basic respiratory and cardiovascular rehabilitation services (pulmonary rehabilitation, COPD)	20 to 35	5,066	0.17	33	0.02	70.2	22	A
21	MR Vaccination	71 to 95	52,358	1.94	37	0.03	5.1	14	A
22	Primary prevention with absolute CVD risk	31 to 50	124,298	5.12	41	0.03	69.0	26	A
23	Management of drug susceptible extrapulmonary TB (adult)	61 to 75	16,326	0.70	43	0.03	67.4	25	A
24	Syndromic management of STI (GUD and Urethral Discharge) (syphilis)	6.0 to 26	10,886	0.49	45	0.03	65.9	24	A

Rank	Nepal intervention	Coverage, baseline to target (%)	HLYs gained	Incremental cost, 5 years (US$ million)	US$ per HLY	× GDP per capita	HAAD (years)	Equity rank	Stream
25	Initial management of gastrointestinal bleeding and referral	48 to 68	2,067	0.11	54	0.04	37.1	23	A
26	Human papillomavirus (HPV) immunization	18 to 95	79,980	5.40	68	0.05	49.1*	21	A
27	Management of acute diarrhoea in adults	11 to 31	17,504	1.20	69	0.05	66.6	29	A
28	Pneumococcal Vaccination	71 to 95	102,647	7.07	69	0.05	45.0	28	A
29	Management of drug susceptible pulmonary TB (adult)	55 to 75	72,886	5.61	77	0.05	66.3	30	A
30	Management of uncomplicated malaria in adult (P vivax/P ovale); Management of uncomplicated malaria in adult (P falciparum/mixed infection); Management of uncomplicated malaria in children (P vivax/P ovale); Management of uncomplicated malaria in children (P falciparum/mixed infection)	73 to 95	23	<0.01	82	0.06	66.8	31	A
31	Emergency management of acute exacerbation of asthma	62 to 80	5,470	0.45	83	0.06	66.1	32	A
32	Screening of cervical cancer and management of pre-invasive cervical cancer	29 to 49	72,752	6.16	85	0.06	54.4	27	A
33	Dental care (caries, tooth extraction, drainage of dental abscess)	16 to 36	14,998	1.30	87	0.06	66.3	33	A
34	Obstetric first aid and referral: Puerperal Infection	56 to 76	989	0.09	89	0.06	65.6	34	A

Rank	Nepal intervention	Coverage, baseline to target (%)	HLYs gained	Incremental cost, 5 years (US$ million)	US$ per HLY	× GDP per capita	HAAD (years)	Equity rank	Stream
35	Basic management of epilepsy	23 to 40	42,094	4.12	98	0.07	65.9	35	A
36	Obstetric first aid and referral: Postpartum Haemorrhage	56 to 76	4,766	0.49	104	0.07	64.7	36	A
37	Emergency management and referral of stroke	33 to 53	2,498	0.27	107	0.07	65.9	38	A
38	Longitudinal management of diabetes mellitus type 1	40 to 60	6,714	0.73	109	0.08	65.4	37	A
39	Management of acute lower respiratory infections in adults (Acute Bronchitis); Management of acute lower respiratory infections in adults (Pneumonia)	37 to 75	68,057	7.42	109	0.08	67.3	39	A
40	Basic respiratory and cardiovascular rehabilitation services (cardiac rehabilitation)	20 to 35	2,772	0.34	122	0.08	64.5	40	A
41	Emergency management of acute exacerbation of COPD	33 to 53	8,033	1.01	126	0.09	68.9	42	A
42	Secondary Prevention of RHD	13 to 33	19,722	2.55	129	0.09	65.2	41	A
43	BCG Vaccination	72 to 95	3,192	0.49	153	0.11	62.9	43	A
44	Tobacco cessation counselling (psychosocial education and psychosocial support)	31 to 50	38,217	7.55	198	0.14	62.8	44	A
45	Brief intervention on alcohol cessation and control	4.0 to 30	4,237	0.86	203	0.14	66.9	45	A
46	Basic physiotherapy for neurological conditions (stroke and others)	20 to 35	625	0.13	211	0.15	70.5	49	A
47	Management of Pelvic Inflammatory Disease (PID)	36 to 70	589	0.14	231	0.16	66.3	47	A
48	Community home-based care for PLHIV	80 to 90	1,055	0.25	233	0.16	65.3	46	A

Rank	Nepal intervention	Coverage, baseline to target (%)	HLYs gained	Incremental cost, 5 years (US$ million)	US$ per HLY	× GDP per capita	HAAD (years)	Equity rank	Stream
49	Safe delivery (Normal labour)	52 to 90	76,874	18.53	241	0.17	62.7	50	A
50	Initial management of psychotic disorders	21 to 41	9,916	2.43	245	0.17	65.9	51	A
51	Initial management of suicide and self-harm and referral	5.0 to 25	1,142	0.29	251	0.17	58.5	48	A
52	Management of depression	27 to 47	42,345	10.63	251	0.17	66.2	52	A
53	Management of wounds and suturing	55 to 75	5,545	1.54	278	0.19	65.8	53	A
54	Initial management of PTSD	10 to 30	18,169	5.09	280	0.19	66.1	54	A
55	Primary Trauma Care (Ptc)	68 to 80	5,859	1.84	314	0.22	65.1	55	A
56	Supportive care for acute hepatitis A (children)	3.0 to 23	6,830	2.19	321	0.22	64.0	56	A
57	Longitudinal management of COPD	24 to 44	24,581	8.10	330	0.23	70.1	60	A
58	Management of multidrug-resistant TB (adult)	20 to 60	8,781	2.91	331	0.23	65.7	58	A
59	Identification and referral of child and adolescent mental and behavioural disorder	4.0 to 24	763	0.26	335	0.23	64.7	57	A
60	Basic management of dementia (Alzheimer's and others)	21 to 41	2,186	0.77	353	0.24	73.4	63	A
61	Management of acute malnutrition among children under 5	19 to 39	15,519	5.57	359	0.25	64.0	59	A
62	Longitudinal management of CVD	17 to 37	10,836	4.23	390	0.27	66.8	62	A
63	Rotavirus Vaccination	71 to 95	7,972	3.29	413	0.29	42.7	61	A

Rank	Nepal intervention	Coverage, baseline to target (%)	HLYs gained	Incremental cost, 5 years (US$ million)	US$ per HLY	× GDP per capita	HAAD (years)	Equity rank	Stream
64	Syndromic management of STI (GUD and Urethral Discharge) (gonorrhoea)	6.0 to 26	28	0.01	427	0.30	65.7	64	A
65	Primary management of common poisoning	23 to 70	25,319	12.78	505	0.35	65.1	66	A
66	Supportive care for acute hepatitis A (adults)	3.0 to 23	3,548	1.89	533	0.37	64.2	65	A
67	Screening and management of Sickle cell and thalassaemia	98 to 100	310	0.19	618	0.43	60.2	67	A
68	Longitudinal management of diabetes mellitus type 2	25 to 45	18,538	13.17	711	0.49	67.7	68	A
69	Management of Substance Use Disorder	7.0 to 27	535	0.45	846	0.58	66.1	69	C
70	Management of Urinary Tract Infection	21 to 42	5,913	6.07	1,027	0.71	66.9	70	C
71	Initial management of bipolar disorders	19 to 39	13,809	15.91	1,152	0.80	65.5	71	C
72	Screening of hepatitis C for PWID	6.0 to 37	11,643	13.79	1,185	0.82	66.9	72	C
73	Longitudinal management of asthma	13 to 33	2,982	4.75	1,593	1.10	66.4	73	C
74	Basic management of migraine and referral	5.0 to 25	25,127	42.78	1,703	1.18	65.9	74	C
75	Management of extensively drug-resistant TB (adult)	32 to 75	242	0.47	1,923	1.33	64.6	75	C
76	Management of acute pharyngitis and acute tonsillitis in children	43 to 63	21,180	47.97	2,265	1.56	55.3	76	C
77	Syndromic management of STI (GUD and Urethral Discharge) (trichomoniasis)	6.0 to 26	610	1.69	2,770	1.91	65.8	77	A

Rank	Nepal intervention	Coverage, baseline to target (%)	HLYs gained	Incremental cost, 5 years (US$ million)	US$ per HLY	× GDP per capita	HAAD (years)	Equity rank	Stream
78	Management of anxiety disorder (GAD, Panic Disorder)	35 to 55	6,951	20.20	2,906	2.01	66.8	78	C
79	Identification, first-line support and referral for survivors of GBV	3.0 to 23	388	1.20	3,088	2.13	65.8	79	C
80	Essential ANC interventions; Management of pregnancy-related thyroid disorder (hypothyroidism)	88 to 95	3,003	11.29	3,758	2.60	25.5	80	C
81	Management of complication of abortion	66 to 85	859	3.86	4,490	3.10	64.4	81	C
82	Syndromic management of STI (GUD and Urethral Discharge) (chlamydia)	6.0 to 26	87	0.44	5,096	3.52	66.3	82	A

Table 42: Interventions without a modelled health gain

Nepal intervention	Incremental cost, 5 years (US$ million)	Stream	Reason
Screening of colorectal cancer	4.72	B	No health gain modelled in FairChoices
Screening and referral of breast cancer	4.71	D	No health gain modelled in FairChoices
Male Sterilization; Female Sterilization: Minilaparotomy	4.60	B	No health gain modelled in FairChoices
Primary palliative care	3.06	B	No health gain modelled in FairChoices
Short acting reversible contraceptives: DMPA; Short acting reversible contraceptives: DMPA s/c	2.34	B	No health gain modelled in FairChoices
Long acting reversible contraceptives: IUCD; Long acting reversible contraceptives: Implant	1.29	B	No health gain modelled in FairChoices
Short acting reversible contraceptives: Combined Oral Contraceptives; Emergency contraceptive pills	0.84	B	No health gain modelled in FairChoices
Polio Vaccination (Oral | IPV)	0.78	B	No health gain modelled in FairChoices
Short acting reversible contraceptives: Condom	0.68	B	No health gain modelled in FairChoices
Medical abortion; Surgical abortion	0.24	B	No health gain modelled in FairChoices
TB preventive therapy	<0.01	B	No health gain modelled in FairChoices
No linked pathway	<0.01	–	No population in need in FairChoices

Note: These interventions have unit costs and budget impact in the BHS costing but no cost per healthy life year gained.

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