

Nepal–WHO Country Cooperation Strategy (CCS) 2018–2022



Government of Nepal
Ministry of Health and Population



**World Health
Organization**
Nepal

Nepal–WHO
Country Cooperation Strategy (CCS)
2018–2022



Government of Nepal
Ministry of Health and Population



World Health
Organization

Nepal

Nepal–WHO Country Cooperation Strategy (CCS), 2018–2022

ISBN: 978-92-9022-641-3

© World Health Organization 2018

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; <https://creativecommons.org/licenses/by-nc-sa/3.0/igo>).

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited, as indicated below. In any use of this work, there should be no suggestion that WHO endorses any specific organization, products or services. The use of the WHO logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: “This translation was not created by the World Health Organization (WHO). WHO is not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition”.

Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization..

Suggested citation. Nepal–WHO Country Cooperation Strategy (CCS), 2018–2022. New Delhi: World Health Organization, Regional Office for South-East Asia; 2018. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at <http://apps.who.int/iris>.

Sales, rights and licensing. To purchase WHO publications, see <http://apps.who.int/bookorders>. To submit requests for commercial use and queries on rights and licensing, see <http://www.who.int/about/licensing>.

Third-party materials. If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

General disclaimers. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers’ products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by WHO to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall WHO be liable for damages arising from its use.

Contents

Message from the Regional Director, WHO, South-East Asia Region	v
Message from the Secretary, Ministry of Health and Population, Government of Nepal	vi
Message from the WHO Representative to Nepal	vii
Executive summary	viii
1— Introduction	1
2— Health and development in a federalized landscape	3
Political development.....	3
Population and economic conditions.....	4
Moving towards universal health coverage.....	6
Health outcomes.....	6
Natural disasters.....	13
Cross-cutting challenges.....	13
Opportunities.....	17
Development cooperation in health sector.....	17
3— The strategic agenda for Nepal–WHO cooperation	19
Strategic Priority 1:.....	20
Strategic Priority 2:.....	24
Strategic Priority 3:.....	29
Strategic Priority 4:.....	32
4— Implementing the agenda—being strategic and delivering results	35
5— Tracking progress – an accountable WHO	40
References	42
Annexures	
1. Mapping of CCS strategic priorities to Nepal Health Sector Strategy, SDG targets and UNDAF outcomes.....	44
2. CCS deliverables monitoring/tracking sheet.....	48
3. Targets to strive for and indicators to measure progress.....	49

Message from the Regional Director, WHO, South-East Asia Region



The Country Cooperation Strategy (CCS) provides a country-specific medium-term strategic vision for the World Health Organization's cooperation with Member States, and outlines the collaborative agenda between the government and the Organization.

Countries in the South-East Asia Region have made significant progress in health in the recent past. Life expectancy in the Region is now 68.9 years, reflecting a rise by 3.5 years per decade since the year 2000. Six countries, including Nepal, achieved the MDG 4 child mortality target. All 11 countries in the Region have developed multisectoral action plans to address NCDs. Maternal and neonatal tetanus has been declared as eliminated from the Region. More than 1.4 million people now have access to treatment for HIV/AIDS. Measles incidence has dropped by 61% since 2000. Preparedness and response to natural disasters is steadily improving, thus reducing casualties. These are truly impressive achievements.

While we are proud of the progress made, more and new challenges are ahead of us in this era of Sustainable Development Goals (SDGs). The rise of noncommunicable diseases, the emergence of antimicrobial resistance, the impact of climate change are just a few examples of how the face of public health is changing. Universal health coverage calls for accessible quality care at an affordable cost—this in itself is a huge agenda that we will need to address.

The factors that define success and influence changes also affect Nepal. In addition, Nepal is going through a process of federalism, which in itself will provide opportunities but also further challenges.

WHO is changing too. It is becoming an Organization that will be more focused on impact, with more accountability, and working with a broader array of partners. That is why this Country Cooperation Strategy for Nepal is both timely and spot on. It outlines WHO's work for the next five years in the key areas that matter most for Nepal, while being rooted in regional and global priorities.

I would like to thank the Ministry of Health and Population and the WHO team in Nepal for performing a rigorous exercise in consultation with stakeholders to identify how WHO can best contribute to a healthier Nepal. The WHO Regional Office is fully committed to provide technical support to advance these priorities, so that the related targets can be achieved.

A handwritten signature in black ink, which appears to read 'Poonam Khetrpal Singh'.

Dr Poonam Khetrpal Singh
Regional Director WHO South-East Asia Region
19 February 2018

Message from the Secretary, Ministry of Health and Population, Government of Nepal

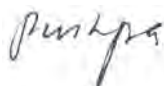


Nepal has in the recent past made significant progress in improving the health of its people. In the last two decades, child mortality has been reduced by 72% and maternal mortality by 52%. Polio has been eradicated. Leprosy has been eliminated at the national level, and the country is on track to eliminate trachoma, kala-azar and lymphatic filariasis. The progress towards achieving the health-related Millennium Development Goals (MDGs) has been impressive. None of these achievements would have been possible without the assistance from development partners, including the World Health Organization.

But challenges remain. Health care is not yet universal: access to quality services at an affordable cost remains a goal rather than an achievement for several groups of Nepalis. The rise in noncommunicable diseases and the constant threat of natural disasters require new approaches. While all countries are turning towards achieving the SDG goals, in Nepal the Constitutional decision for the country to become a federalized state, brings with it its own challenges and opportunities. The way Nepal will deliver health services will change. More than before, we are looking at WHO and partners for continued support.

I am pleased that the 2018–2022 Country Cooperation Strategy recognizes these emerging needs and focuses WHO’s work on key areas where its support will have most impact. For the first time, the Nepal CCS clearly identifies targets and deliverables, thus allowing assessment of the effectiveness and impact of WHO’s work in Nepal.

The Ministry of Health and Population welcomes this joint strategy as a guiding framework for WHO’s technical cooperation in Nepal. We look forward to working together with WHO to advance four strategic priorities which we think are a best fit in Nepal’s changed context.

A handwritten signature in black ink, appearing to read 'Pushpa'.

Dr Pushpa Chaudhary

Secretary, Ministry of Health and Population
Government of Nepal
18 February 2018

Message from the WHO Representative to Nepal



This WHO Country Cooperation Strategy for Nepal is the third strategy of its kind and builds on the lessons learnt from past performance. The strategy is intended as a roadmap to drive collaborative work between WHO, the Government of Nepal and other health sector stakeholders. This new CCS comes on the start of a federalization process in Nepal which will require the country office to adapt, not just to newly emerging health issues but also to a changed country context.

The strategy builds on existing national health sector policies, strategies and plans, and takes into account the impact of and the ongoing federalization process. Moreover, WHO's Thirteenth General Programme of Work (GPW), Regional Flagship Priorities, and health-related SDG targets were also considered carefully when drafting the document. The CCS is the result of an iterative consultation process with the Ministry of Health and Population (MoHP) and its departments, concerned professional councils, health related external development partners (EDPs), as well as WHO colleagues at regional and HQ levels.

The CCS identifies four strategic health areas that are priorities for Nepal. And to be fit-for-purpose in the current context, the CCS focuses on key focus areas and proposes new ways of working: more collaborative, more target- and outcome-oriented, and more transparent and accountable.

I would like to express my sincere thanks to the WHO CCS Working Group and the MoH Review Group who were instrumental in developing this strategy. Likewise, I would like to thank health sector EDPs, national stakeholders, and colleagues from WHO HQ and the regional office who provided their technical inputs while developing this strategy. And last but not least, my sincere gratitude goes to the consultants Dr Eigil Sorensen and Mr Amit Aryal for turning ideas into a workable document.

We look forward to working with the Government of Nepal and partners towards turning this roadmap into action.

A handwritten signature in black ink, appearing to read 'Jos Vandelaer', written over a horizontal line.

Dr Jos Vandelaer
WHO Representative to Nepal
19 February 2018

Executive summary

Nepal has made impressive progress in health outcomes relative to its income level. Life expectancy has been steadily increasing and Nepal's progress in reducing maternal and child deaths has been lauded internationally, even though the maternal mortality remains the highest in the South-East Asia Region. There are notable achievements in reducing prevalence of HIV and TB and Nepal is on track to be malaria-free by 2025. Aggregate improvement in health outcomes, however, mask the large urban–rural, gender, poverty, ethnicity and caste inequities.

Following decades of political uncertainty, the country is going through a political transition from a unitary state to a federalized structure with new roles and responsibilities for local, provincial and federal governments. Nepal's newly endorsed Constitution enshrines the right to healthy living and access to health services as a fundamental human right. It guarantees every citizen with the right to free basic health services from the State, emergency health services, and equal access to health services. This implies a significant restructuring of the state and provides an enviable opportunity to re-organize the health systems around the principles of universal health coverage.

While closely following these historic developments, the CCS is also informed by the aspirational national policies and strategies—National Health Policy (2014) and Nepal Health Sector Strategy (2015–2020)—and its international commitments made by the Government of Nepal, and the Sustainable Development Goals (SDGs). It was developed in consultation with senior officials in the Ministry of Health and Population, partners and WHO Country Office staff. A CCS Committee was formed in the Ministry of Health and Population that provided technical guidance for its development. Several rounds of discussions with Secretary of Health, senior management of the Ministry of Health and Population, and the Regional Office, coalesced around four strategic priorities for WHO over the next five years.

Four strategic priorities for WHO collaboration in Nepal 2018–2022:

- (1) Advancing universal health coverage in a federalized governance structure.
- (2) Effective delivery of priority public health programmes.
- (3) Enhance health security and disaster preparedness and response.
- (4) Multisectoral engagement and partnerships for improved health outcomes.

Looking ahead, it is paramount that WHO in Nepal seek to forge meaningful partnerships with other government agencies, other ministries, UN agencies and non-State actors to address important public health problems and to influence the social,

economic and environmental determinants of health. This marks an important departure and a more pro-active engagement of WHO in the SDG era.

WHO will need to extend its support beyond the federal ministry to subnational levels, to accommodate changes being introduced under a federalized form of governance. The Organization will focus on its competitive advantages, and define the scope of its support, in alignment with government priorities and harmonized with development partners. The Organization will be more accountable regarding its commitment to achieving agreed-upon targets and deliverables.

1 — Introduction

The Country Cooperation Strategy (CCS) provides a medium-term strategic vision for World Health Organization's cooperation with a particular Member State in support of that country's national health policies, strategies and plans.

This Country Cooperation Strategy guides World Health Organization's work in Nepal 2018–2022. This strategy is informed by the aspirations of the National Health Policy (2014), Nepal Health Sector Strategy (2015–2020), international commitments made by the Government of Nepal, Sustainable Development Goals (SDGs), WHO's Regional Flagship Priorities and the Thirteenth General Programme of Work. The strategy draws on the mandate, expertise and comparative advantage of WHO as the world's leading public health organization. It takes stock of the previous CCS period and draw upon lessons for the future. It also elaborates on the recently endorsed UNDAF's (2018-2022) strategic priorities related to health. As a Member State, this strategy presents an opportunity for Government of Nepal to identify and influence WHO's global priorities, relevant to Nepal.

The CCS was developed in consultation with the WHO Country Office staff, senior officials in the Ministry of Health and Population, and partners. A CCS Committee was formed in the Ministry of Health and Population that provided technical guidance for its development. Several rounds of discussions were held with SEARO for technical inputs, and with the Secretary of Health and senior management of the Ministry of Health and Population, who provided guidance to the document and approved its content.

The previous CCS was for the period of 2013–2017, that coincided with significant developments in the country's political landscape. During this time a historic new Constitution was ratified by Parliament in April 2015 and, along with came the birth of the Federal Democratic Republic of Nepal. For the first time in Nepal's history, the participatory Constitution-making process ensured fundamental human rights to citizens, including the right to health. During this period, Nepal also received international accolades for the significant reductions in maternal and child mortality.

Some of these developments and the recommendations of the mid-term review in 2015 warranted WHO to modify its strategies to better reflect the country's health sector needs. Key positions were created and filled on health systems and health information, two key priorities for the ministry as the country transitions into federalized structures. Additional support was also provided to the health ministry on federalism and sharing experiences of other countries that have recently gone through similar processes.

All tiers of the government will in the future have critical roles to play in implementing Nepal's progressive policies on health and ensuring the political commitment to universal health coverage enshrined in the Constitution. These political developments also have

significant implications for a Member State based organization like WHO, which will support the Government of Nepal to effectively manage this transition period while preserving the public health gains over the last couple of decades. This will require WHO to be flexible in its programming over the next CCS period, 2018–2022 and focused on realizing universal health coverage and other SDG goals. Such flexibility will also apply to addressing needs in emerging health fields which may not be explicitly mentioned in this document. WHO’s specific role in addressing such needs, and the re-prioritization of activities that goes with it, will be determined through on going dialogue with the government and partners.

2 — Health and development in a federalized landscape

Nepal has made impressive progress in health outcomes relative to its income level, but large inequities between urban–rural areas persist and health is severely impacted by poverty. The country is going through a political transition from a unitary state to a federalized structure with new roles and responsibilities for local, provincial and federal governments with many challenges ahead, but also with great opportunities to improve the health of its people.

Political development

Nepal has undergone substantial political changes over the last three decades. Responding to the aspirations of the Nepali people, on 17 September 2015, the second Constituent Assembly ratified a new Constitution, transforming the country from unitary state into a Federal Democratic Republic. The new Constitution institutionalizes inclusive and participatory democracy with specific civil and human rights, including the right to a clean environment (Article 30) and the right to health as specified in Article 35:

- (1) Every citizen shall have the right to free basic health services from the State, and no one shall be deprived of emergency health services.
- (2) Every person shall have the right to information about his or her medical treatment.
- (3) Every citizen shall have equal access to health services.
- (4) Every citizen shall have the right of access to clean drinking water and sanitation.

Additionally, Article 38 recognizes women’s rights to reproductive health and safe delivery services.

Three levels of government, federal, provincial and local, will replace the traditional unitary system of government and with it introduce substantial devolution of powers to lower levels of government. The responsibility to deliver “basic” health services will be the sole responsibility of local governments, while the federal government will largely change its responsibilities to policy-making, regulations, standards development and monitoring. These functions of the federal government are a substantial departure for the Ministry of Health and Population, which traditionally also prepared the annual programming and budgeting with the decentralized health offices merely implementing them.

Elected leaders in all 753 local governments were in place as of September 2017 following completion of local elections in three phases (1). This was a historic event for Nepal after an absence of locally elected representatives for nearly two decades

following prolonged political transition. The newly elected local leaders have already assumed their power and responsibilities entrusted to them by the Constitution. The provincial and federal governments will be in place following the elections held in December 2017. The structure and number of ministries at the federal and provincial levels remain to be finalized and will likely be decided when the newly elected government takes its place.

Following the election, functional Constitutional structures in all tiers of government is expected to be set up. Unlike local governments where there are existing physical structures and practices in participatory governance, provincial governments are coming to fruition for the first time in Nepal's history. Similarly, all public health programmes were run through 75 district health offices right until December 2017. They have been the nodal centres for managing all resources and delivering services. As health services need to be much more peripheral in nature—in contrast to say financial services—finding the right system to deliver public health services in the absence of these district control nodes will be a key challenge. During this transition period, it will be important for WHO to be a reliable partner for the federal government as it devolves roles and responsibilities to provincial and local governments, while also building on the public health gains achieved in Nepal over the last couple of decades.

Population and economic conditions

Nepal's population was approximately 26 million in 2011 and is projected to exceed 33 million by 2030(2). Despite this expansion, the population growth rate is decreasing. Outflow of migrants, mostly of the economically productive age-group, was almost 2 million in 2011. The decreasing fertility rate has dampened the average annual growth rate of population from 2.3% between 1991–2001 to 1.4 % in the following decade between 2001 to 2011(2).

The Terai makes up about 50% of the total population, with 43% residing in the Hills and 7% in the mountain regions(2). Agricultural land and employment opportunities bring people to the Terai from other regions, a phenomenon which has slowed over the recent years. Nepal has witnessed rapid urbanization resulting in doubling of its urban population from 9% in 1991 to 20% in 2017, although some of this increase is the result of merging rural units into urban and municipal areas(2). Rapid urbanization coupled with limited access to primary health services, has negatively impacted the health of urban residents, particularly the poor.

The Government of Nepal joined the Family Planning 2020—a global partnership—with the commitment to policy and programmatic interventions to expand family planning services(3), particularly among underserved populations. While unmet need for family planning decreased from 28% to 25%, less than half the women used modern methods of family planning (46%) and demand satisfied with modern methods has stagnated at 56%(4).

Use of family planning is lower among poor women and adolescents compared with the national average, and their unmet need for family planning is higher(3). In order to reach replacement rate by 2021, contraceptive prevalence rate for modern methods will need to reach 50% and unmet need will need to be reduced to 22%. These will require targeted interventions for the poor and vulnerable groups, adolescents and youth, and those living in rural areas and migrant population groups(3).

The government allocates a high proportion of the budget to essential services (11.2%) relative to the SEA Region on health, education and social services (SDG indicator 1.a.2)(5). This, however, masks the proportional decrease in public budget allocation to health with only 3.9% spent on health during fiscal year 2016–2017, compared with 6.3% in 2005–2006(6). The low and decreasing proportion of the national budget for health has encouraged the private sector to substantially increase its investments to meet the increasing demand for health services. Compared with only 16 privately managed hospitals in 1990, there were 301 by 2014(7). As a result, people are increasingly using privately managed pharmacies and hospitals, transferring a large financial burden for health care (56%) on individuals(8). This underscores the need for increase in the government's commitment to health in order to fulfil its Constitutional mandate and, at the same time, realize universal health coverage.

Human development

Nepal has made significant progress in poverty reduction and human development in the last two decades. Despite protracted political instability, absolute poverty decreased from 42% in 1995 to 25% in 2010 and further to 21.6% in 2015, resulting in improvement of the Human Development Index(9). Still, one in five Nepalese live in absolute poverty, among the highest in South Asia, and the country is at the bottom of the countries with middle human development status(9).

There are large disparities among social groups, gender and geographical areas, and many remain on the threshold of poverty, making them susceptible to even minor shocks. For example, in 2011, poverty in the mountains was most prevalent at 42% in contrast to an average of 9% in the urban hills and the percentage of poor in the far western development region is 46% in 2011 compared with 21% in the eastern region(9).

On the heels of the new Constitution, the priority of the government has been to reduce absolute poverty, achieve fundamental rights of the citizens, and minimize the disparity in development outcomes across gender, social class and geographical regions. Nepal also aims to graduate from the least developed country (LDC) status by 2022 and emerge as a middle-income country by 2030. For this, the government is targeting 7% annual economic growth rate, which seems challenging given the average growth rate of 4% over the last decade.

Moving towards universal health coverage

The Government of Nepal has progressively introduced policies aimed at achieving universal access to health care for all Nepali citizens. The Free Health Care Policy launched following the Second People's Movement in 2006 gave people access to select essential medicines in public health facilities. By 2009 the policy was revised to expand the "basic" package to cover all outpatient, inpatient and emergency services, as well as essential medicines, up to district level hospitals. Additionally, the Ministry of Health and Population delivers specialized and referral health services through its network of tertiary, speciality and academic hospitals, mostly located in urban areas across the country.

Alongside the expansion of the basic health package, the government continues to expand free access to long established priority public health programmes through the rural-focused district health system and, in some cases, provide demand-side incentives for utilization of these services, such as ANCs and delivery, treatments for TB, etc. The government also established the *Bipanna Nagarik Kosh*, starting in 2012, which provides financial subsidies for impoverished citizens covering 12 diseases to pay for expensive treatments in empanelled hospitals. These include subsidies for treatments for kidney dialysis and transplant, all cancers, head and spinal injuries, Parkinson's, Alzheimer's and thalassemia, among others(10).

Health has historically been financed largely by the government budget, external donor funds and out-of-pocket. Starting in 2013, the government began scaling up health insurance through a public body, the Social Health Security Development Committee. As of January 2018, the committee was operating health insurance in 25 of 75 districts with relatively low coverage of approximately 5%(6). The landmark National Health Insurance Act was endorsed by Parliament in October 2017 and is anticipated to fundamentally change the way health services are financed in Nepal(11). It carries an individual mandate—all citizens must enrol—with premiums for the poor, disabled, orphans and the elderly paid for by the government. It also introduces a payer-provider split for the first time in the country. "Basic" health services, which need further review, will be provided free of charge to all citizens and insurance is expected to cover a package of service beyond the basic package.

Health outcomes

Nepal has made impressive progress in health outcomes relative to its income level. Life expectancy has been steadily increasing to 65 years in 2011, compared to 55 years two decades earlier (see Table 1). Nepal's progress in reducing maternal and childhood deaths has been lauded internationally. Under-five mortality rate has declined over the last couple of decades to 21 per 1000 live births in 2016. The maternal mortality ratio has decreased to 239 per 100000 live births in 2016, but remains the highest in

the SEA Region(12). There are also notable achievements in reducing prevalence of HIV and TB, while the government remains committed to be malaria-free by 2025.

Figure 1: Trends and targets in childhood mortality

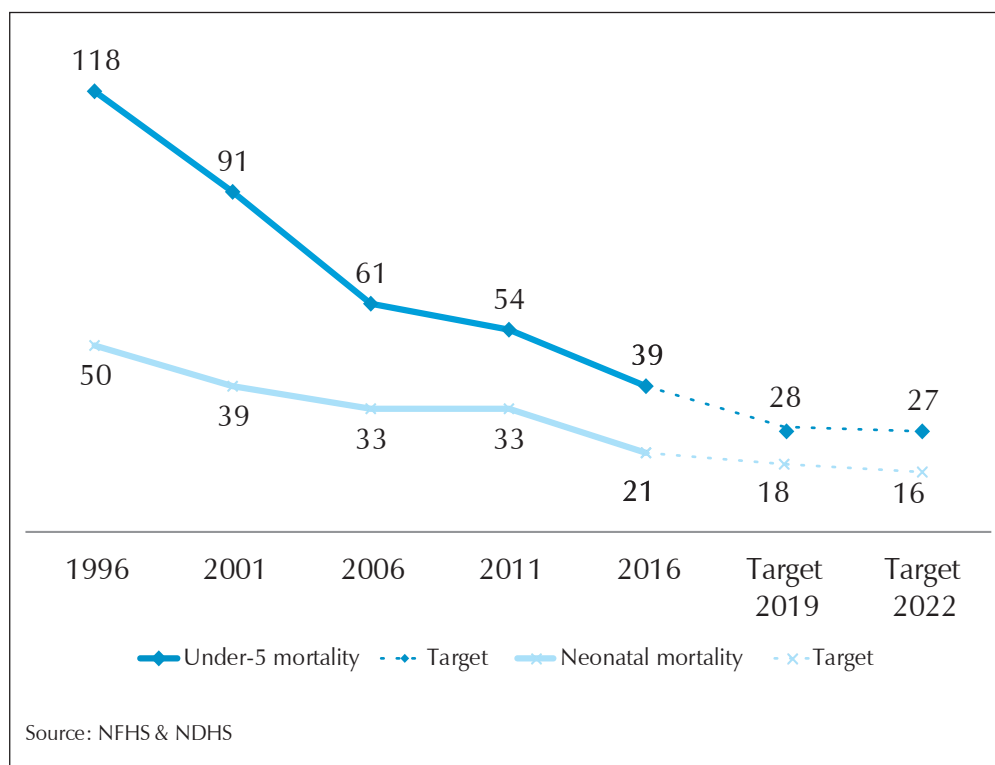


Table 1: Selected health and population indicators

Indicators		1991	2011	Latest available statistics
Total population (millions)		18.5	26.5	28.4 (CBS, 2016)
Population < 15 years (%)		42.4	34.9 (CBS, 2011)	30.56 (CBS, 2016)
Population > 60 years (%)		5.8	8.1 (CBS, 2011)	8.43 (CBS, 2016)
Population in urban areas (%)		9.2	17.1 (CBS, 2011)	62.4% (CBS, 2016)
Life expectancy at birth (years)	Female	53.5	67.9 (CBS, 2011)	70.8 (WHO, 2015)
	Male	55.0	65 (CBS, 2011)	67.7 (WHO, 2015)

Indicators	1991	2011	Latest available statistics
Fertility rate (births per woman)	5.16	2.6 (NDHS, 2011)	2.3 (NDHS, 2016)
Adolescent fertility rate (births per 1,000 women ages 15-19)	127 (1996)	81 (NDHS, 2011)	88 (NDHS, 2016)
Neonatal mortality rate (per 1000 live births)	50	33 (NDHS, 2011)	21 (NDHS, 2016) 22.2 (WHO, 2015)
Under-five mortality rate (per 1000 live births)	118 (1996)	54 (NDHS, 2011)	39 (NDHS, 2016) 35.8 (WHO, 2015)
Maternal mortality ratio (per 100000 live births)	539 (1996)	281 (NDHS, 2006)	239 (NDHS, 2016) 258 (WHO, 2015)
Proportion of women of aged 15–49 years who have their need for family planning satisfied with modern methods ¹ (%)	32% (1996)	56 (NDHS, 2011)	56 (NDHS, 2016) 56 (WHO, 2015)
Proportion of births attended by skilled health personnel (%)	-	36 (NDHS, 2011)	58 (NDHS, 2016) 56 (WHO, 2015)
% DTP-3 Immunization coverage among one-year-olds (year)	54 (1996)	91 (NDHS, 2011)	86 (NDHS, 2016) 91 (WHO, 2015)
Current health expenditure as percentage of GDP (%)	-	5.2 (NHA, 2012)	6.15 (WHO, 2015)
General government expenditure on health as % of total government expenditure (year)	-	7.25 (NHA, 2012)	11.2 (WHO, 2014)
Health expenditure per capita (USD)	-	36 (NHA, 2012)	44.4 (WHO, 2015)
Out-of-pocket payment as % of current health expenditure	-	53 (NHA, 2012)	60.41 (WHO, 2015)
Physicians density (per 1000 population)	-	0.18 (HRH Profile, 2013)	-

Indicators	1991	2011	Latest available statistics
Nursing and midwifery personnel density (per 1000 population)	-	0.50 (HRH Profile, 2013)	-
Adult (15+) literacy rate total (women men)	-	67 87	-
Population using improved drinking water sources (%)	-	89 (NDHS, 2011)	89 (NDHS, 2016) 92 (WHO, 2015)
Population using improved sanitation facilities (%)	-	38 (NDHS, 2011)	89 (NDHS, 2016) 46 (WHO, 2015)
Poverty headcount ratio at USD 1.90 a day (2011 PPP) (% of population)	61.9 (1995)	15.0 (WB, 2011)	-
Gender-related Development Index rank out of 148 countries	-	113	115 (2015)
Human Development Index rank out of 186 countries	-	157	144 (2016)

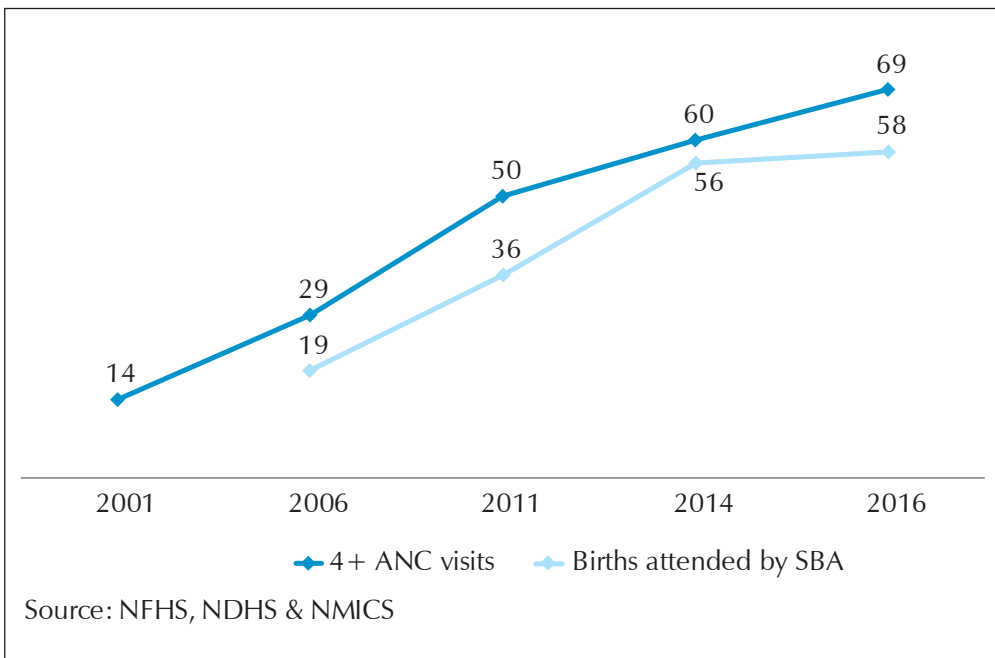
Source: Population Monograph of Nepal: Volume I (2014), Nepal Demographic Health Survey (2006,2011,2016), World Health Statistics (2017), National Health Accounts (2017), Global Burden of Disease - Institute of Health Matrix and Evaluation, Human Resources for Health: Nepal Country Profile (2013), World Bank - Global Poverty Working Group, Human Development Report (2016)

¹ Married women only.

There are large inequities in terms of urban–rural location, mother’s education and household wealth status as well as among geographical regions. Children born in rural areas are more likely to die before their fifth birthday than those born in urban dwellings and children in the poorest households are twice as likely to die before reaching one and five years of age compared with children living in the richest households. These challenges underscore the need for continued commitment to improve the survival of mothers and newborns, particularly vulnerable population groups(13).

The targets set by the Millennium Development Goals (MDGs) motivated increased focus and investment in maternal and child health programming to reduce the under-five mortality rate by two thirds and maternal mortality ratios by one half by 2015 from the 1990 levels. Increasing coverage of immunizations and the Safe Delivery Incentive Programme, which later evolved to the *Aama Surakshya Programme* (Safe Motherhood Programme), provided free-of-charge deliveries to all mothers, including financial incentives for four scheduled ante-natal care (ANC) check-ups and for delivering at health facilities (14). These evidence-based interventions are credited with improving survival of mothers and their children.

Figure 2: Trends in maternal health



While the reduction in child mortality is significant, the neonatal deaths remain high and account for 54% of all under-five mortalities(15). This has a direct relationship with the quality of services for these population groups, underscoring the need to focus on quality to shift the needle on these indicators. In response, the Ministry of Health and Population, in 2017, endorsed Nepal’s Every Newborn Action Plan in 2017 with aims to scale up evidence-based public health interventions by revising the Community-Based Integrated Management of Childhood Illness (CB-IMCI) to include critical newborn interventions while enhancing the capacity of district and referral hospitals to treat newborn complications(16). Over the last few years, the Family Health Division has expanded facility-based interventions aimed at improving quality of care for children and neonates and expanded the Maternal and Perinatal Death Surveillance and Response (MPDSR) programme to promote the notification, review and response to eliminate preventable maternal and perinatal deaths.

Community-based programmes have proved to be successful in diagnosing and treating childhood illnesses and are credited with reducing the rates of fatalities from pneumonia from 0.4 to 0.12 per 1000 under-5 children between 2000 to 2014 and for diarrhoea in from 0.4 to 0.07 per 1000 under-5 children during the same period (17). Alongside these efforts, the government has set an aggressive target to deliver basic level of water services and improved sanitation for all by the end of 2017. As of 2014, 93% of the population have access to basic water supply services and 62% have access to basic sanitation facilities (15). While coverage has increased, more than 80%

of household members continue to be exposed to *Escherichia coli* (*E. coli*) risk levels in their water, exposing children to illnesses (Central Bureau of Statistics, 2014).

In 2017, the National Immunization Programme provided 11 antigens free of charge for children as are treatments for childhood illness through public health facilities and outreach efforts in communities. It has been one of most successful public health campaigns contributing to reduction in child mortality and over the last decade increased antigens provided to children from 6 to 11. Today, as little as 1% of children in Nepal do not receive any vaccinations compared to 20% in 1996(13). While the aggregate coverage is impressive (78%), children from rural communities or living in the Terai and mountain regions are less likely to receive all basic vaccinations. The most striking disparities are of children in Province 2, where only 65% received all basic vaccinations(13).

Communicable diseases

Communicable diseases account for approximately 18% of all deaths in Nepal down from over 32% in 2000(18). Free-of-charge diagnosis and treatment to the public are available for TB, HIV and malaria through public health facilities. Driven by MDG-6 to halt and reverse their trends, the Government of Nepal has identified all three (TB, HIV and malaria) as priority programmes and invested in achieving the MDG goals.

Treatment success rate for TB has remained above 90% over the previous five years. However, the TB cases notification rate remains stagnant at approximately 60%. Nepal has formally adopted the End TB Strategy with a short-term goal of reducing TB incidence by 20% by 2021 compared with the rate in 2015 and increase case notifications by a cumulative total of 20000 from July 2016 to July 2021. Achieving these and effectively tackling the growing burden of multidrug-resistant TB will require accelerated efforts to enhance health facility diagnosis capacity with emphasis on outreach efforts, joint actions against TB and tobacco and other risk factors, and partnerships with the private sector (19).

The Ministry of Health and Population's efforts to expand coverage of testing and antiretroviral treatment (ART) services, while coordinating efforts between HIV and maternal and child health programmes have minimized new infections and increased treatment options for people infected by HIV. These efforts have resulted in a significant decline of HIV/AIDS cases. The estimated HIV prevalence among young adults (15–49 years) has dropped from a peak (0.35 %) in 2005 to 0.17% in 2016 and is expected to remain around 0.13 in 2020. While they are impressive, Nepal must continue to focus its efforts in improving the low coverage of ART care (30 %) if it is to achieve the 90-90-90 targets(20).

Nepal has low hepatitis B and hepatitis C prevalence (<2%); but the data is limited. There are sporadic outbreaks of hepatitis E during the rainy season often related to lack

of proper sanitation and hygiene. The introduction of birth-dose hepatitis B vaccine is still under consideration by the government(21).

Nepal met the MDG-6 target for malaria by reducing its morbidity and mortality rates by more than 50% by 2010. With declining parasite incidence, the Government of Nepal has planned to eliminate Malaria by 2025(22). However, WHO has listed Nepal as one of the 21 countries with the possibility of malaria elimination by 2020.

Nepal's geography, the presence of vectors and the high percentage of rural populations with limited access to safe water, sanitation and essential medicines and poor living conditions makes it vulnerable to neglected tropical diseases. Sustained efforts over the last couple of decades have resulted in notable achievements. While there are endemic districts that need further attention, Nepal met the national elimination targets for leprosy in 2010. It is committed to elimination of trachoma, kala-azar and lymphatic filariasis by 2020. Nepal has sustained national elimination target required for Kala-azar elimination since 2013.

Non-communicable diseases

Noncommunicable diseases (NCDs) account for a large and increasing proportion of deaths and disability. Deaths attributed to NCDs in Nepal have risen from 51% in 2010 to 60% in 2014(23). Cardiovascular diseases, diabetes, cancer, chronic respiratory diseases, mental disorders and oral diseases account for the major NCDs burden in Nepal. Suicide was reported as the leading cause of death among women of reproductive age (16%) by a survey conducted in 2008(24). Surveys also reveal high tobacco use, high alcohol consumption, low fruit and vegetable consumption, physical inactivity, obesity and instances of overweight among the population(25). These are further exacerbated by unchecked air pollution, under-regulated urbanization, traffic-related injuries and natural disasters.

In response, the Government of Nepal endorsed the Multisector Action Plan for the Prevention and Control of NCDs (2014–2020), which highlights priority diseases to be tackled: cardiovascular diseases, diabetes, chronic respiratory diseases, cancers, mental health, oral health, as well as road traffic accidents. Its implementation has been challenging, especially coordinating strategic interventions across multisectoral stakeholders and line ministries.

The Ministry of Health and Population has continued to fulfil its commitments by expanding public health programming for control and prevention of NCDs. It carried out the STEPS survey that highlighted prevalence of risk factors for NCDs. The National Health Research Council is conducting the first ever national mental health survey. On the programmatic side, the ministry is gradually expanding the Package of Essential Noncommunicable (PEN) diseases nationwide– as of October 2017 it was available in 10 of 75 districts.

There have also been appreciable efforts to better regulate the market of products harmful to human health. In the fiscal year 2016–2017, it stepped up its coordination with the Ministry of Finance and the Ministry of Home Affairs to effectively implement regulations on tobacco and alcohol products. The MoH also proposed increasing taxes on alcohol products and it is including studying tax increases in sugary drinks. Starting the fiscal year 2016–2017, it launched a nationwide health promotion campaign aimed at persuading people to adopt healthy lifestyles under the banner of “*Mero Barsa*”. Its impact remains to be assessed. Despite these efforts, implementation of regulations and taxes along with health promotion activities are unsatisfactory and further lobbying with respective ministries is required.

Natural disasters

Nepal is prone to natural disasters including earthquakes, floods, landslides, avalanches, fires and the outbreak of diseases. These disasters have often undermined the achievements made in poverty reduction and human development while posing serious challenges to human health security. Once such event was the catastrophic earthquakes that struck Nepal on 25 April and 12 May 2015. As many as 8790 people lost their lives and more than 22000 people sustained injuries. It also inflicted significant damage to structures(26). In total, almost 500000 homes were fully damaged and hundreds of historical and cultural monuments at least a century old were either destroyed or extensively damaged; 500 health facilities were destroyed beyond repair and another 760 facilities sustained partial damage(26). The disaster also exposed inequities in Nepali society. Poorer rural areas have been more adversely affected than towns and cities due to their inferior quality of houses and more women and girls died than men and boys(26).

The National Reconstruction Authority was formed by the Government of Nepal to oversee the recovery efforts. Among other responsibilities, it is responsible for reconstruction of health facilities. To date, 230 prefabricated structures have been setup in place of fully damaged health facilities with the rest requiring retrofitting or rebuilding are to be completed by 2020(27).

The earthquake proved to be a stark reminder of Nepal’s vulnerability to natural disasters. Achieving the SDGs with better human development outcomes will require further investment in adequate disaster risk reduction and preparedness strategies.

Cross-cutting challenges

Despite the substantial expansion of modern health services to rural areas and the subsequent progress in the health status of citizens in recent decades, there are grave challenges that require consistent and sustained efforts. The country needs to focus on improving quality of care from community levels to hospital-based care alongside the important agenda of realising the universal coverage of care. Maternal and neonatal

mortalities at birth of the mother and child remain high, rates of malnutrition, particularly among children, women of reproductive age, and the elderly is reason for concern, while access to clean drinking water and sanitation is still low. Furthermore, the country has also witnessed a rapid rate of urbanization because of migration from villages to urban cities, putting enormous pressure on the fragile urban health system.

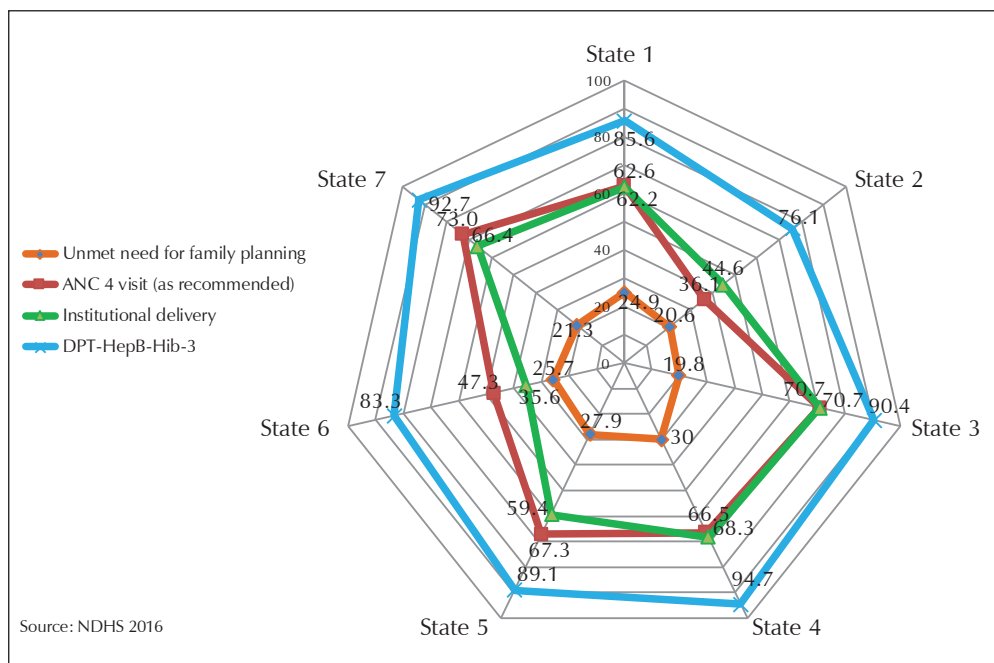
Equity and gender

Inequities in health utilization and outcomes exist between ecological zones, development regions, urban and rural areas, the poor and better-off, genders, and caste and ethnic groups. Barriers to access and use of health services exist due to persistent cultural norms, weak financial capacity, large physical distance and difficult terrain, and irregular availability of skilled health workers and essential medicines, especially in hard-to-reach areas. While implementing this strategy, WHO, in collaboration with other UN agencies and development partners, will ensure that specific attention is given to areas or provinces that are lagging behind in terms of UHC coverage.

Trend data from the past three NDHS show that while the inequality in several outcome indicators by poverty groups has declined, the gap remains sizeable(28). For example, 89% of women in the wealthiest quintile delivered with a skilled provider, compared with 34% in the poorest(29). Significant differences by caste and ethnicity also persist: 46% of Brahmin/Chhetri women delivered with a skilled birth attendant but only 27% of Dalit women(28).

The Ministry of Health and Population endorsed the Health Sector Gender Equality and Social Inclusion Strategy (2009) to improve the policy environment for mainstreaming gender equity and social inclusion, improve capacity of providers, and improve health-seeking behaviour of marginalized populations(30). The strategy provided the impetus to create specific interventions in efforts manage gender-based violence, and create social support units (SSUs) in hospitals to support poor and excluded populations utilize critical health services. While these interventions have been important, public health programmes do not adequately capture gender and inclusion issues and tackle GESI as a separate component. Therefore, a holistic and strategic approach to mainstreaming gender and inclusion is needed in the health sector.

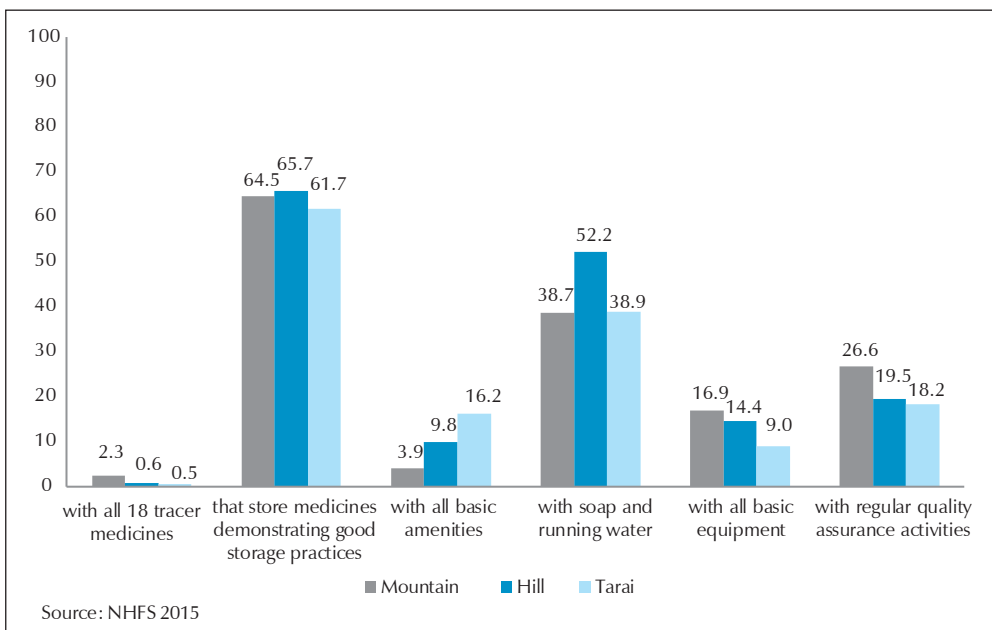
Figure 3: Health services coverage indicators in seven states



Quality of care

Sectoral health policies and strategies have stressed the importance to improve quality of care with limited success(31)(32)(33). There are, however, successful quality improvement strategies in priority health programmes that can offer lessons for the broader sector. Evidence-informed and well-resourced strategies have resulted in increases in women delivering in health institutions, increased deliveries by SBA and reduced disparities, contributing to reductions in maternal and newborn mortalities. Interventions in improving management of health institutions by introducing management standards coupled with funds for quality improvement and performance incentives have also improved institutional performance (34).

Figure 4: Health facility readiness to provide quality health services



These achievements have been made despite persistent issues with the absence of and low skill levels of health workers, stock-out of drugs and commodities, and poorly maintained infrastructure and equipment(35)(36). Newly elected local governments will have the authority and resources to resolve some of these persistent issues. There are also important roles for federal and yet-to-be-formed provincial governments. These include developing policies for accelerating production of key cadres, deploying and retaining health workers, facilitating timely procurement of quality medicines and commodities, and developing and enforcing standards for quality of care across both public and private providers.

Health workforce

Central to the aspirations of universal coverage of basic health is the availability, distribution and performance of health workers. The mid-term review of the previous sector strategy, Nepal Health Sector Programme (NHSP)-II, expressed concerns about health workforce management in Nepal and identified it as a “bottleneck” to progress in both access and quality of public health services(37). There are high proportions of vacancies and absenteeism coupled with maldistribution of the workforce and lack of up-to-date data on the current stock and distribution. The sector is also facing a shortage of health workers in relation to the size of the population. The HRH Profile (2013) showed that there were only 1.05 health workers per 1000 population compared to an indicative threshold of 4.45 per 1000 population to achieve the SDGs (38)(39).

Additionally, there is a disparity between the focus of curriculums and the health needs of communities across the country.

There has been an exponential growth in privately managed training institutions and medical schools following the opening of the sector to private investment in 1990. According to the Nepal Medical Council, there are 21 medical schools in Nepal that impart five-year MBBS degrees, 16 of which are privately managed with at least five more waiting to be licensed(40). Concomitant expansion of institutions offering Master's level courses have not kept pace with only five institutions offering specialised courses. Further, the rapid privatization has been at the expense of quality in medical education, a fact borne out by low clearance rate (35%) of licensing examinations(41). Following political pressure from civil society, the Cabinet endorsed a Higher Medical Education Act in October 2017 after several attempts failed in the recently dissolved Parliament to reign in the expansion of medical education and improve its quality.

The ministry's HRH Strategic Plan 2011–2015 aimed to address these challenges, but its implementation is unsatisfactory. It remains important for the government to endorse a comprehensive health workforce strategy that institutionalizes systems and processes that prioritize accelerated production of key cadres of health workers and broader regulation of the education sector along with their deployment, incentives for retaining them, their capacity development measures, and an updated data management system.

Opportunities

Federalism provides a great opportunity to reform the out dated vertical and horizontal structures needed to attain greater equity, efficiency, effectiveness and accountability. Decentralized health sector planning and budgeting promise to enhance transparency with meaningful participation of communities and informed by evidence.

Health is influenced by many factors beyond health-care services: individual lifestyle and behaviours, as well as the wider social determinants such as education, income, employment, housing, security, macroeconomic situation and environmental factors. Partnerships with relevant line agencies, local governments, academia, and private and non-profit institutions should be effectively utilized for mutual benefit and to ensure universal access to affordable health care for all citizens.

Development cooperation in health sector

Sector-wide Approach (SWAp) continues to foster meaningful partnerships between the government and development partners to achieve improved health outcomes for the Nepali people. It has been instrumental in scaling up evidence-based service delivery initiatives and fostering streamlined financial and technical cooperation in the sector. Various instruments such as Joint Annual Review (JAR), Joint Financing Arrangement

(JFA), Joint Coordination Mechanism and Health Sector Development Partners Forum, as guided by the International Health Partnership (IHP+), have further enhanced the SWAp. Currently, 12 external development partners (EDPs) are formal signatories to the SWAp; DFID and KfW pool their funds under direct budget support, while World Bank, DFID, and GAVI subscribe to the disbursement linked indicators (DLI).

The Government of Nepal's preferred modality to channel financial cooperation through General Budget Support and Sector Budget Support is in congruence with the calls of high-level aid platforms such as Accra and Busan to which the Government of Nepal and most health EDPs are also party to(42). The efficacy of JAR as a platform for reviewing progress against results has improved over the years and so has the overall results-orientation of the MoH. However, there is a recognized need to improve the integration of the NHSP processes into the ongoing government sector planning and review process while ensuring that annual sectoral reviews are better integrated with planning and budgeting processes.

Additionally, WHO also participates with other UN agencies to develop and revise United Nations Development Assistance Framework (UNDAF) and engages with the Resident Coordinator and United Nations Country Team (UNCT) under this framework. Through UNDAF, WHO seeks to strengthen dialogue among UN funds, programmes and specialized agencies and foster a multisectoral approach to achieve national health priorities, such as reduction and control of NCDs, and mobilizes additional resources to do so.

The Ministry of Health and Population has greatly benefited from other forms of equally significant partnerships with wide-ranging internal and external actors. Global health initiatives (GHIs) such as the Global Fund (The Global Fund to Fight AIDS, Tuberculosis and Malaria) and the GAVI Alliance (Global Alliance for Vaccines and Immunization) have been important to deliver disease-specific health interventions in Nepal. The Association of International NGOs (AIN), the NGO Federation of Nepal, and for-profit sectors also continue to play a significant role in development of Nepal's health system as have specific models for engaging the non-State actors namely, Parapokar, Netra Jyoti Sangh, Nyaya Health, Rotary Nepal and missionary hospitals. While these and other meaningful opportunities exist, they are engaged by the MoH on an ad hoc basis, underscoring the need for a strategic partnership policy while strengthening institutional capacity to incentivize and regulate both public and private providers.

3 — The strategic agenda for Nepal–WHO cooperation

The new Constitution institutionalizes that every citizen shall have the right to free basic health services from the State, no one shall be deprived of emergency health services, and that every citizen shall have equal access to health services. The Nepal Health Sector Strategy (NHSS) 2015–2020 is built on the idea that health is an integral and indivisible part of the nation’s socioeconomic development and investment in health is fundamental to further national development. The strategic priorities accentuate WHO’s contribution to the goals set out in the Constitution and NHSS.

WHO Nepal has been supporting the Government of Nepal for over 60 years towards achieving better health for all people in Nepal. In the period covered by this CCS (2018–2022), WHO will continue this support, with a stronger focus on technically assisting the government in achieving existing goals and targets. Within the SDGs, addressing current health issues requires an ever more comprehensive approach, and WHO intends to also work closely with other ministries and partners. WHO will furthermore extend its support to subnational levels, to accommodate changes being introduced under a federalized system. WHO will focus on its competitive advantages, and define the scope of its support in alignment with government priorities and harmonized with development partners. The Organization will be more accountable regarding its commitment to achieving agreed-upon targets and deliverables.

Four Strategic Priorities have been identified in the CCS:

- (1) **A**dvancing universal health coverage in a federalized governance structure,
- (2) Effective delivery of priority public health programmes,
- (3) Enhance health security and disaster preparedness and response,
- (4) Multisectoral engagement and partnerships for improved health outcomes.

Annex 1 provides a mapping of the CCS Strategic Priorities and the linkage to the Nepal Health Sector Strategy 2015–2020 priorities, SDG targets and UNDAF outcomes.

The CCS identifies key areas of what WHO will do to achieve the strategic priorities and a set of priority deliverables in support to the government. The deliverables do not cover all what the Organization will do, but provide an accountability framework for a large part of WHO’s work in Nepal.



Strategic Priority 1:

Advancing universal health coverage in a federalized governance structure

Situation assessment

The Federal form of governance introduced by the new Constitution implies a significant restructuring of health services. Many details of the practical implementation of federal governance and its implications for the health sector have still to be worked out. This provides an opportunity to pursue and advocate for universal health coverage, but also carries considerable risks for a potential setback to primary health care until the full implementation and the capacity of the local government are established. Of special concern would be the potential negative impact on vulnerable groups such as women, children and poor people's access to quality health services. The transition period, therefore requires major inputs and focus from WHO assisting the Government both in the design and implementation phase of all aspects of health system strengthening. Federalization will also require a new set of public health policies and legislation.

Focus area 1.1 Strengthen health systems to deliver basic health services at local government level

WHO will:

- (1) Assist the Ministry of Health and Population in defining the basic health package and minimum standards in health facilities, and its implications for provider payment mechanisms and health financing.
- (2) Facilitate that the local governments and health workers understand the basic health package, standards and treatment guidelines and ensure they are easily available (e.g. webportal).
- (3) Build capacity in public health and health administration to strengthen health systems to deliver the basic health package at provincial and local government level.
- (4) Monitor, document and analyse the implementation of the basic health package and the quality of care under 753 local governments.
- (5) Assist the Ministry of Health and Population in providing opportunities for professional development of health workers at the primary health care level, in particular online access to international best practices.

CCS deliverables

The basic health package for each level of care is defined and agreed upon, including NCDs, mental health, preventive and promotional activities.

Easy access to updated standards and treatment guidelines related to the basic health package is established.

Monitoring framework of local government health facilities is operational.

Toolkits for capacity-building on public health governance and management for local and provincial health ministries is developed.

Annual universal health service coverage report with focus on basic health care at local government level is prepared.

Training packages, specifically geared towards primary-level providers, is published online, regularly expanded and updated.

Focus area 1.2 National oversight and policy development

WHO will:

- (1) Support evolution of the federal restructuring proposing delineation of roles and responsibilities, setting standards and public health legislation.
- (2) Support HR planning and development, including required HRH management capacity at the federal, provincial and local government level.
- (3) Support the review of minimum requirements for curriculums of courses in medicine, nursing, pharmacy and paramedics in collaboration with training and academic institutions, Ministry of Health and Population, Ministry of Education and other line ministries, councils and professional societies.
- (4) Provide technical support to the health resource tracking (National Health Accounts) to ensure the regular monitoring of the health expenditure for policy-making and financial protection tracking as part of UHC monitoring.
- (5) Facilitate health-financing policy-making, ensuring a robust and consistent legal framework and a strategic and operational plan that strengthens the strategic purchasing function.
- (6) Build national capacity of regulatory authority for ensuring quality, safety and efficacy of regulated medicines, vaccines and health products and improve pharmacovigilance.
- (7) Provide technical support to the Ministry of Health and Population for regulation of private health care and facilitate that private health service providers follow national protocols and standards.

- (8) Provide technical support to strengthen quality of care mechanisms, particularly to strengthen Accreditation and Quality Authority and establishment of clinical audit systems.
- (9) Provide technical support to strengthen Health Management Information System (HMIS) in the federated context for reporting, in particular on UHC and the health-related SDGs.
- (10) Expand quality and coverage of birth and mortality statistics and use of ICD-10 in hospitals in line with the mortality statistics improvement plan.
- (11) Provide technical support to develop national eHealth architecture, interoperability framework and standards. Leverage use of information and communications technology (ICT) to advance implementation of eHealth strategy.
- (12) Stimulate health system research related to federalization and public health by setting of research priorities that meet needs of the country.
- (13) Engage with professional societies and academic institutions for institutionalizing continual professional development promoting public health, evidence -based best practices and quality of care in health service delivery.
- (14) Promote collaboration between academic and national training institutes and WHO collaborating centres to enhance their capacity to run specific courses in priority areas of public health and health service delivery.
- (15) Provide basic technical support to newly established provincial Ministries of Health.
- (16) Ensure effective coordination of partner support to avoid fragmentation and identify gaps as federalization is evolving.

CCS deliverables

- A conceptual framework of universal health coverage in the Nepalese context developed.
- Health-financing strategy developed to ensure efficient and effective distribution and utilization of health resources; a federal health financing transition plan/strategy (provincial and local level) formulated.
- National Health Accounts (NHA) at national level and subnational/provincial level after 2018 produced annually and institutionalized, including policy briefs, dialogues, documents development based on the NHA and national guideline for the NHA production.

- HRH Strategic Roadmap updated in line with new service delivery structure, service package and staffing norms and improved data: periodical and thematically guided HRH documents produced for planning.
- Performance licensing examinations for medical doctors based on competency of skills developed.
- National Health Workforce Accounts (NHWA) institutionalized and producing national statistics on an annual basis.
- Assessment of the Department of Drug Administration (DDA) using WHO Global Benchmarking Tool for national regulatory authorities and DDA's Institutional Development Plan developed.
- National policy for planning and management of procurement for essential medicines, vaccines and health commodities.
- Presence at provincial level to provide guidance and technical assistance to provincial governments liaising with the WHO Country Office and Federal Ministry of Health and Population.



Strategic Priority 2:

Effective delivery of priority public health programmes

Situation assessment

Nepal has achieved significant reduction in child mortality and also increased life expectancy. Nepal was recognized in 2014 for being on track in maternal mortality reduction, but did not achieve the MDG target, and its maternal mortality ratio is the highest in the South-East Asia Region. Communicable diseases are no longer the dominant cause of morbidity and mortality. New vaccines provide opportunities, in particular for improved child health. The country has achieved polio-free status in 2013 while measles, malaria, kala-azar and trachoma are on the track to elimination. These achievements need to be sustained and further improved, but major challenges remain in areas such as tuberculosis.

Focus area 2.1 Tuberculosis control

WHO will:

- (1) Support the TB control programme to improve diagnosis and treatment with special focus on case detection, strengthening laboratory system, drug-resistant TB and tuberculosis in vulnerable populations, including children.
- (2) Support the continuation of the TB and tobacco integration in primary care through Practical Approach to Lung Health (PAL) and DOTS strategy.
- (3) Advocate for private-public mix and community engagement in the TB control programme.
- (4) Support the National TB Prevalence Survey (2018) along with conducting the second Drug-Resistance TB Survey in 2019.

CCS deliverables

- Update technical guidelines that define laboratory standards and protocols, particularly for rapid drug-susceptibility testing (DST) and drug-resistant tuberculosis.
- Conduct the Annual Review of the TB programme at national and subnational levels.
- Complete the high-quality TB Prevalence Survey and the second drug-resistance TB survey.

- Develop the rapid response plan and guidelines for TB in a post-disaster situation.

Focus area 2.2 Elimination of measles, malaria and selected neglected tropical diseases

WHO will:

- (1) Provide technical assistance for maintaining polio-free status in the country and developing a successful polio transition plan.
- (2) Provide technical assistance aimed at achieving measles elimination by 2019.
- (3) Provide technical assistance aimed at elimination of malaria by 2025, lymphatic filariasis by 2020, trachoma by 2018, kala-azar by 2020, and leprosy at the provincial level by 2020.
- (4) Strengthen surveillance and laboratory diagnostic system for elimination-targeted neglected tropical diseases (NTDs), specifically for malaria and kala-azar.
- (5) Coordinate regular cross-border collaboration/activities for efficient case reporting and tracking of malaria and selected NTDs including dengue and chikungunya.
- (6) Provide technical assistance in re-evaluating the epidemiological situation and interventions for soil-transmitted helminthiasis.

Female Community Health Volunteer (FCHV) administering anti-filariasis drug in a school



CCS deliverables:

- International surveillance performance standards for polio, measles and rubella achieved.
- Updated guidelines on case management, case and foci investigation, vector control and outbreak response for NTDs and malaria.
- Validation of the elimination at national level of trachoma and kala-azar.
- Transmission Assessment Survey (TAS) conducted for lymphatic filariasis control and elimination in endemic districts.

Focus area 2.3 Introduction of new vaccines and control of vaccine preventable diseases, including combating hepatitis

WHO will:

- (1) Provide technical assistance for introduction of new vaccines (fractional IPV in 2018, rotavirus vaccine in 2018, HPV in 2019).
- (2) Provide technical support for improving immunization coverage with focus on equity.
- (3) Provide technical support for control of rubella/congenital rubella syndrome (CRS).
- (4) Support the development and implementation of national hepatitis strategy and action plan based on the disease burden and cost-effective interventions.
- (5) Provide technical assistance for informed decision-making over hepatitis B vaccination policies, in the context of WHO SAGE recommendation.

Child immunization during national polio campaign



CCS deliverables

- Quarterly monitoring of immunization data undertaken.
- Disease burden estimates for hepatitis infection updated and plan for implementation of National Hepatitis Surveillance in place.
- Testing and treatment guidelines for HBV/HCV infection updated.
- Integrated community-based services for the prevention and control of viral hepatitis as part of universal health coverage.

Focus area 2.4 Promoting health through the life course

WHO will:

- (1) Support the implementation of Maternal and Perinatal Death Surveillance and Response (MPDSR), and Newborn and Birth Defects Surveillance (SEAR-NBBD) linked with improved quality of maternal and newborn care.
- (2) Support the development of capacity-building package for facility-based Integrated Management of Neonatal and Childhood Illnesses (IMNCI).
- (3) Provide technical support for developing guidelines, national plans and strategies on geriatric care, sub-fertility and infertility, and women's and adolescent health.

Grandmother bringing her grandchild to the health facility for check-up



CCS deliverables:

- Community-based MPDSR programme expanded in 25 districts by 2022, and hospital-based surveillance of newborn and birth defects expanded.
- IMNCI guidelines, treatment protocols and training package and ECD (early childhood development) package developed and integrated within the basic health package.
- Technical guidelines and guidance materials to support implementation of national strategies for progress in women's, children's health and adolescent health updated in line with "Survive, Thrive and Transform" objectives of the Global Strategy.



Strategic Priority 3:

Enhance health security, disaster preparedness and response

Situation assessment

The country is still in the recovery phase after the earthquake of 2015 that affected 35 districts. The new WHO Health Emergencies Programme, adding operational capabilities to the traditional technical and normative roles of the Organization, will require that the work of the country office is reorganized and further strengthened. Nepal is one of the contributors to the Bangkok Principles for the implementation of the health aspects of the Sendai Framework for Disaster Risk Reduction 2015–2030. Nepal currently does not meet all IHR Core Capacity requirements. WHO will work with the government and partners to enhance national capacity in line with the Asia Pacific Strategy of Emerging Diseases and Public Health Emergencies (APSED III). Delineation and development of key Core Capacities are also needed at subnational levels following federalization.

Focus area 3.1 Achieve compliance to IHR (2005)

WHO will:

- (1) Provide technical support to attain and sustain IHR Core Capacities for surveillance, response and points of entry.
- (2) Support development of the national framework for decentralized management of public health emergencies, through risk assessment, response and risk communication.

Simulation exercise for management of influenza outbreak at a hospital



CCS deliverables

- Joint External Evaluation of IHR Core Capacities completed.
- National action plan to fill IHR Core Capacity gaps in place.
- National public health laboratory plan updated, including the establishment of functional public health laboratories at provincial level.
- National multi-hazards health security plan developed.

Focus area 3.2 Detect and respond to public health emergencies

WHO will:

- (1) Assist in the establishment of a comprehensive, integrated and sustainable National Disease Surveillance and Response System, especially for outbreak-prone infectious diseases and other public health risks.
- (2) Enhance the national and subnational technical and operational capacity to manage disease outbreaks and other unusual events of public health significance.
- (3) Technical assistance using the Global Task Force on Cholera Control (GTFCC) aimed at achieving cholera elimination.
- (4) Develop and maintain optimal capacities at the WHO Country Office augmented by support from the regional and global levels to effectively implement the WHO Emergency Response Framework (ERF) during national and regional public health emergencies.

CCS deliverables

- The institutional and human resources capacity-building strategy for implementation of the National Disease Surveillance and Response System in the federated context completed.
- The establishment of a One Health focused National Field Epidemiology Training Programme facilitated.

Building of a health facility damaged due to earthquake



Building of a health facility reconstructed after earthquake



- Standardized strategies and service packages (public health and medical interventions) for emergency response and recovery during disease outbreaks and disasters developed.
- Functional Public Health Emergency Operation Centres (PHEOC) established in provinces in coordination with partners.
- SEA Region Benchmark Assessment for health sector emergency preparedness and response readiness at provincial level completed.

Focus area 3.3 Early warning, risk assessment, preparedness and emergency response to disasters

WHO will:

- (1) Provide technical support for disaster risk reduction (DRR) interventions in the health sector.
- (2) Build disaster management capacity at decentralized levels.
- (3) Support the establishment of hospital networks with appropriate pre- and post-hospital service linkages in provinces in coordination with partners for ensuring hospital preparedness and response to disasters.
- (4) Enhance sectorwide and partner coordination and action for disaster management at decentralized levels.

CCS deliverables

- The health sector component of the national plan for implementation of the SENDAI DRR Framework completed.
- Standardized Framework for Assessment of Disaster Risk (Hazard, Vulnerability and Capacity) in the health sector developed.



Strategic Priority 4:

Multisectoral engagement and partnerships for improved health outcomes

Situation assessment

It is widely recognized that multisectoral action is central to the SDG agenda and many of the health gains come from sectors outside of health. Collaboration with all stakeholders will apply throughout WHO's work in Nepal, but here are outlined the top priorities where the strategic focus will be achieved through multisectoral action. NCDs pose a major challenge to Nepal's health-care system with deaths due to NCDs having increased from 51% of all deaths in 2010 to 65% in 2015. The World Health Assembly approved in 2016 a new "Framework of engagement with non-State actors" (FENSA). The objective was for WHO to enable more effective, efficient and transparent engagements with civil society, the private sector and academic institutions. WHO in Nepal would like to involve non-State actors and other government agencies and ministries to address important public health problems and to influence the social, economic and environmental determinants of health. This marks a more pro-active engagement of WHO in the SDG era in close cooperation with other UN agencies.

Focus area 4.1 Combating antimicrobial resistance (AMR)

WHO will:

- (1) Engage with stakeholders across sectors to promote rational use of medicines, and reduce over-the-counter sale of antibiotics and advocacy for AMR prevention and containment programme in line with the national action plan.
- (2) Build capacity for laboratory-based surveillance.
- (3) Use traditional and social media to educate the public and health professionals on the risk of AMR.

CCS deliverables

- Laboratory-based AMR surveillance in place.
- Establish a mechanism for annual assessment of national antibiotic consumption.

Focus area 4.2 Reducing risk factors for noncommunicable diseases

WHO will:

- (1) Provide leadership, advocacy and partnership to accelerate national multisectoral response for prevention and control of noncommunicable diseases, to promote healthy lifestyles and to reduce exposure to key NCD related risk factors.
- (2) Provide technical support to strengthen NCD governance capacity.
- (3) Advocate and provide technical support to accelerate the full implementation of FCTC.
- (4) Provide technical advice on taxation and regulation of tobacco, alcohol and sale of sugary drinks.
- (5) Use social media to promote healthy lifestyles, tobacco-free environment, and reduce exposure to key NCD-related risk factors and stigma associated with mental disorders.
- (6) Provide technical support to ensure that legal, policy and strategic frameworks required are in place to accelerate implementation of mental health action plan 2013–2020.

CCS deliverables:

- Multisectoral Action Plan for Prevention and Control of Noncommunicable Diseases 2021–2025 updated and technical support for implementation and promotion of multisectoral engagement continued.
- Mental Health Act and National Suicide Prevention Strategy developed through a consultative process with parties concerned and technical support provided for implementation.

Focus area 4.3 Address the impact of environmental health and climate change

WHO will:

- (1) Provide technical support and advocacy on ambient and indoor air pollution, in particular for Kathmandu Valley, in line with WHO air quality guidelines.
- (2) Conduct research on health outcomes related to air pollution and urban living.
- (3) Provide technical assistance to implement the health component of national adaptation plan to climate change.
- (4) Provide technical assistance for water quality surveillance.

CCS deliverables:

- National strategy to address health impacts of air pollution developed.
- Results and analysis from water and air quality surveillance published regularly.
- Experiences of urban planning interventions addressing health equity documented and communicated.
- Advocacy programmes on health impacts of hazardous use of chemicals are organised regularly.

A team performing water quality surveillance



4 — Implementing the agenda – being strategic and delivering results

The Strategic Priorities are implemented through the biannual workplans and human resource plan aligned with the CCS. WHO is undertaking reforms with emphasis on delivering measurable results, providing value for money and optimizing organizational performance. As federalisation is being rolled out, WHO's engagement will adapt and adjust according to the new institutional structures and respond to the needs of a health sector undergoing transformation. Implementation of the agenda will depend on effective collaboration and the endorsement by the national government and local bodies and provinces of in targets and deliverables agreed upon in this strategy.

Strategic support and policy dialogue

WHO intends to deliver on the four Strategic Priorities through stronger technical support and enhancing the way the Organization is working in Nepal. WHO will focus resources where the impact on the health of the people of Nepal is the greatest and WHO can make a distinct contribution. This means shifting of funding from many small activities to more strategic support that can build strong health systems.

WHO will strengthen its role in driving a policy dialogue building on the Organization's normative functions. With federalization, evidence-based health policies and practices are even more important. WHO will use its leverage bringing special expertise and experience to the table and create a dialogue and a place for innovation on public health issues with national and subnational counterparts and institutions, partners and non-State actors. Many issues such as social health insurance and eHealth are evolving, providing new emerging opportunities. Discussing and applying global standards and best practices, in addition to the analysis and use of strategic information, will underpin the policy dialogue.

When adopting global and regional strategies and frameworks, WHO will assess to what extent they fit to Nepalese context and, if necessary, adapt to the specific needs of the country.

Visible WHO leadership

WHO will use its position for strategic engagement with government and key stakeholders in health. The Strategic Priority on multisectoral engagement and partnerships for improved health outcomes suggests a new role for WHO in addressing health determinants more effectively with various line ministries, civil society, professional societies, academic institutions and the private sector. As a member of the existing group of External Development Partners, the Organization will use its convening power for

advocacy on health issues with special emphasis on pursuing equity, UHC and the SDG agenda and leading the partners around the NHSS and national health agenda.

Working as “One WHO”

The Country Cooperation Strategy 2018–2022 for Nepal represents the commitment from all the three levels of the WHO Secretariat. Technical expertise will be sought from all throughout the Organization– from headquarters in Geneva, the Regional Office, and other country offices (“South-south cooperation”), and WHO collaborating centres to ensure that most relevant and optimal support can be provided. Staff in the Country Office will receive backstopping from the Regional Office and WHO headquarters as and when required. Technical support will as much as possible be provided through a team approach rather depending on a single technical expert to ensure optimal technical inputs, continuity and sustainability.

WHO will continue to facilitate regional and cross-country exchange of ideas, sharing of experiences, and coordination of activities on public health, health service delivery and universal health coverage.

Part of United Nations family

WHO will work closely with the partner agencies within the UN system to pursue the SDGs and the health agenda, while recognizing the mandate and comparative advantage of the different agencies as outlined in the UNDAF. Special areas of collaboration will be NCDs, reproductive and child health, governance, climate change, environmental health and disaster preparedness and response.

High-quality technical assistance

WHO wants to be an effective and efficient provider of high-quality technical assistance and support to Nepal. The Organization aims at technical excellence and recognizes that has not always been the case in the past. More emphasis will be given to evaluation of short-term and long-term technical assistance.

WHO will consequently also review its Country Office staff and team structure and adjust to the strategic priorities set out in the CCS and the need for high-quality technical support. This implies more effective work across the teams and breaking down silos between programmes. Internal convergence between programmes is required to achieve better results and maintain the quality of work, dealing more effectively with cross-cutting issues such as surveillance, health information system and monitoring and evaluation.

Adjusting the teams will go together with the physical relocation of some of the staff members within the office. This should go along with refurbishing of the office premises to have a more conducive working environment that promotes effective collaboration,

dialogue and communication between the staff. Pursuing technical excellence during a period of country transformation involves continuous discussions and dialogue within the office, with counterparts and partners.

WHO will continue to work closely with partners such as DFID, GIZ, USAID, World Bank and UN agencies that are providing technical assistance in Nepal, and where appropriate, explore more intense collaboration with relevant partners. This to ensure effective cooperation, avoiding overlap, and with the goal that technical support contributes to a real national capacity-building. Whenever feasible, WHO will formalize partnerships on technical assistance and be looking for possibilities of partners funding WHO technical support where the Organization has a comparative advantage, including from the Global Fund and GAVI.

Institutionalizing capacity-building

It has been suggested that WHO needs to do more to institutionalize capacity-building and that technical reports and policy documents are not enough to build technical competencies and skills. WHO will therefore place more emphasis on continued technical support working with counterparts over time to facilitate real national capacity-building. Debriefing of short-term technical experts with counterparts and plans for follow-up being in place along with evaluations and performance assessments of technical support must be ensured.

WHO will promote collaboration between academic and national training institutes and WHO collaborating centres to enhance their capacity to run specific courses in priority areas of public health and health service delivery.

A robust health system strengthening team

The Country Office will require a strong HSS team of 6–8 experts at the national level with a mix of internationals/nationals (long-term/short-term), and a pool of consultants with relevant expertise who are involved over time to support federalization. To do so, WHO will require additional financial resources. The transition to the federalized governance structure from 2018 necessitates that the major inputs are available from the beginning of the biennium 2018–2019.

The main WHO support will continue to be at the national level. However, WHO will also have a limited presence in provinces, where possible sharing office premises with other UN agencies in line with the spirit of “Delivering as One”. The main objective of this will be to build capacity in public health and health administration at the provincial and local government level.

Increased operational capacity in emergencies

The new WHO Health Emergencies Programme, adding operational capabilities to the traditional technical and normative role of the Organization, will require that the work of the Country Office be reorganized. WHO will draw on the pooled resource within the organization in times of crisis or public health emergencies.

Bhaktapur Hub Hospital Emergency Logistics Warehouse with stockpiles



Gender and human rights focus

WHO will train Country Office staff on gender responsive budgeting (GRB) in cooperation with the other UN agencies and make it mandatory to perform gender and equity analysis for any plans or strategic activities. Equity and human rights perspective will be applied in all programmes and along with use of disaggregated data focusing on gender and equity. Any policies, strategies and plans supported by WHO will have specific approaches to reach the unreached.

Coordinating with the government

Regular update of program planning and implementation and annual reporting on the CCS deliverables will be shared with government counterparts through regular meetings between the Ministry of Health and Population and WHO. This will also serve as a forum to discuss areas of improvements for the collaborative work.

Communicating effectively

WHO will be more visible and communicate more effectively while advocating and shaping the health agenda. It will also take advantage of the Internet and social media, recognizing the fact that an increasing number of health workers and the general population in Nepal, in particular young people, are using social media on a daily basis.

The Country Office will have a communication expert who will assist the Head of the Country Office and the technical staff to interact with local media and on social media, working in close cooperation with the UN system.

WHO will promote better utilization by government, academic and training institutions of the Organization's online technical resources.

Managing risks

Nepal is undergoing a major reform of the governance and political system, and this carries significant uncertainty and risks that could hamper the progress of WHO's work in the country. The advantage is that WHO has a long-term commitment and presence in Nepal, and is able to adjust to political changes.

WHO has not yet ensured the funding to deliver on the CCS strategic priorities. The CCS is a commitment from the whole of WHO so the Organization will do its best to mobilize the necessary resources in collaboration with donors and partners. Pursuing the strategic priorities in cooperation with partner agencies can mitigate the risk of insufficient funding for WHO.

The recruitment process has in the past often been prolonged. The expectations are that the global WHO reform process will improve recruitment to ensure that staff with technical excellence are in the right place at the right time, failing which could hinder the implementation of the CCS.

5 — Tracking progress – an accountable WHO

The Evaluation Policy and the WHO Reform process stress developing a culture of evaluations at all levels of the Organization. The purpose is to improve performance, provide opportunity for organizational learning and pursue accountability of results. Consequently, the CCS has identified specific deliverables facilitating easy tracking of progress of WHO's work in Nepal, and thus will function as an accountability framework for the Organization.

The following elements will be part of the monitoring and evaluation of the CCS:

Annual progress report

A simplified progress report based on tracking of the CCS deliverables using a “traffic light system” will report on the progress towards achieving deliverables (Annex 2). This will be done in addition to the regular technical and financial reporting through the Global Management System (GSM) for the implementation of the biannual workplans. The annual progress report, to be published on the Country Office's website, will function as an early warning system to alert the Country Office to adjust if necessary the biennial workplans, review staff structure, or seek additional technical support from the Regional Office or headquarters.

The annual workplan for each staff member included in the Performance Management and Development System (PMDS) will be directed towards the deliverables in the CCS.

Mid-term review

A mid-term review will be conducted with the aim to determine whether the progress is on track, identify impediments and other factors or developments that may require changes to the strategic priorities or focus areas, and decide on actions required to improve progress during the second half of the CCS cycle. The outcome of the mid-term review can also guide the biennial country programme planning.

Final evaluation

The final evaluation at the end of the CCS cycle is a more comprehensive assessment than the mid-term review. The focus is to measure the achievements set out in the CCS strategic priorities and deliverables. Furthermore, it will also evaluate how the CCS has contributed to the national realization of the health-related SDGs. National, regional and global targets guiding the CCS are provided in Annex 3. The objective will also be

to identify critical success factors and impediments, lessons learnt and how these can be applied in the next CCS cycle.

Participants of Lessons learnt conference: Health sector response to Nepal Earthquake 2015



The Country Office with the support of the Regional Office and headquarters will be responsible for conducting the mid-term review with external support as required. The final evaluation will be conducted by an independent team not connected to WHO. The WHO Evaluation practice handbook will be used as a reference point. The reports will be published online and shared with the government and partners. When relevant, the mid-term and final evaluation can be linked or be part of other ongoing evaluations.

The results of the mid-term review and final evaluation will be published on the WHO Country Office website.

Monitoring working group

A joint working group from the Ministry of Health and Population and WHO will be established to track the progress and discuss challenges and key issues in implementing the CCS and the biannual workplans. The working group will meet at least once a year or whenever there is a need, and will also oversee the planning and completion of the mid-term review and final evaluation. The group will also assess to what extent policy frameworks, institutional arrangements, and sector contribution and inputs are in place to support the achievement of the agreed deliverables.

References

- (1) Republica. 73% voter turnout in historic local polls. [Online] September 15 May, 2017. [Cited: October 20, 2017.] <http://www.myrepublica.com/news/20111/>.
- (2) Central Bureau of Statistics. National Population and Housing Census 2011 (Population Projection 2011-31). Kathmandu: Central Bureau of Statistics, 2014.
- (3) Ministry of Health. FP 2020. Kathmandu: Ministry of Health, 2015.
- (4) Nepal Demographic Health Survey - Key Indicators. Kathmandu : Ministry of Health, 2016,
- (5) World Health Organisation. World Health Statistics 2017. Geneva, 2017.
- (6) Annual Progress Report of Health Sector Fiscal Year 2015/16. Ministry of Health. Kathmandu: Ministry of Health, 2017.
- (7) Central Bureau of Statistics. Census of Private Hospitals. Kathmandu : Central Bureau of Statistics, 2013.
- (8) Ministry of Health. National Health Accounts 2011-12. Kathmandu : Ministry of Health, 2017.
- (9) UNDP Nepal Human Development Report 2014. Kathmandu : Government of Nepal, 2014.
- (10) Ministry of Health. Bipanna Nagarik Aushadhi Upachaar Kosh Nirdeshika (Second Amendment), 2073. Kathmandu: Ministry of Health, 2016
- (11) Ministry of Health. National Health Insurance Act. Kathmandu, Nepal : Ministry of Health, 2017.
- (12) WHO, UNICEF, UNFPA, The World Bank, and United Nations Population Division. Trends in Maternal Mortality: 1990 2013. Geneva : 2014.
- (13) Ministry of Health. Nepal Demographic Health Survey - KI. Kathmandu : Ministry of Health, 2016.
- (14) Family Health Division. Aama Surakchya Programme Implementation Guideline. Kathmandu: Ministry of Health, 2009.
- (15) Central Bureau of Statistics. Nepal Multiple Indicator Cluster Survey. Kathmandu : UNICEF, 2014.
- (16) Ministry of Health. Nepal's Every Newborn Action Plan. Kathmandu : Ministry of Health, 2017.
- (17) Department of Health Services. Annual Report 72/73. Kathmandu: Ministry of Health, 2016.
- (18) World Health Organisation. Global Health Estimates. Geneva, 2015.
- (19) Department of Health Services. Annual Report 2072 | 73. Kathmandu : Ministry of Health, 2017.
- (20) Ministry of Health. National HIV Strategic Plan, NHSP 2016-2021. Kathmandu : Ministry of Health, 2017.
- (21) World Health Organization, Regional Office for South-East Asia Regional action plan for viral hepatitis in South-East Asia: 2016-2021. Version July, 2017
- (22) National Malaria Strategic Plan (2014–2025). Kathmandu : Ministry of Health, 2015.
- (23) World Health Organisation. Noncommunicable Diseases Country Profiles. Geneva, 2014.
- (24) Family Health Division. Nepal Maternal Morbidity and Mortality Survey. Kathmandu: Ministry of Health, 2009.
- (25) National Health Research Council. Non-Communicable Diseases Risk Factors: STEPS Survey. Kathmandu: National Health Research Council, 2014.
- (26) NPC. Post-Disaster Needs Assessment. Kathmandu : National Planning Commission, 2015.
- (27) National Reconstruction Authority. Rebuilding Nepal. Kathmandu : National Reconstruction

- Authority, 2017.
- (28) Ministry of Health. Nepal Demographic and Health Survey 2011. Kathmandu : Ministry of Health, 2012.
 - (29) Nepal Demographic Health Survey 2016 - Key Indicators. Kathmandu : Ministry of Health, 2017.
 - (30) Health Sector Gender Equality and Social Inclusion Strategy . Kathmandu : Ministry of Health, 2009.
 - (31) Government of Nepal. National Health Policy. Kathmandu : Government of Nepal, 2014.
 - (32) Nepal Health Sector Programme II (2010-2015). Kathmandu : Government of Nepal, 2010.
 - (33) Daniels, David, Kapil Ghimire, Poonam Thapa, Marc Réveillon, Deb Raj Pathak, Kedar Baral, et al. Nepal Health Sector Programme II Mid-Term Review. Kathmandu : Ministry of Health, 2013.
 - (34) Ministry of Health. National Annual Health Review 73 |74. Kathmandu, Nepal : Ministry of Health, November 2016.
 - (35) Service Tracking Survey 2013. Kathmandu : Ministry of Health, 2014.
 - (36) Nepal Health Facility Survey 2016. Kathmandu : Ministry of Health, 2016.
 - (37) Mid-Term Review NHSP-II. Kathmandu : Ministry of Health, 2013.
 - (38) Human Resources for Health: Nepal Country Profile. Kathmandu : Ministry of Health, 2013.
 - (39) World Health Organization. Global Strategy on Human Resources on Health: Workforce 2030. Geneva, 2016.
 - (40) Nepal Medical Council. Recognized Institutions - Medical College . [Online] Nepal Medical College, 2017. [Cited: November 5, 2017.] www.nmc.org.np/recognized-institution/medical-college.html
 - (41) Kathmandu Post. Between right and wrong. *Kathmandu Post*. [Online] Kathmandu Post, August 9, 2017. [Cited: November 5, 2017.] <http://kathmandupost.ekantipur.com/news/2017-08-09/between-right-and-wrong.html>.
 - (42) Government of Nepal. Development Cooperation Policy. Kathmandu : Government of Nepal, 2014.

Annexures

Annex 1. Mapping of CCS strategic priorities to Nepal Health Sector Strategy, SDG targets and UNDAF outcomes

CCS Strategic Priorities	Focus Areas	NHSS Priorities ²	SDG Targets ³	UNDAF Outcomes
1. Advancing universal health coverage in a federalized governance structure	Focus area 1.1 Strengthen health systems to deliver basic health services at local government level	<p>OP1a1 Improved staff availability at all levels with focus on rural retention and enrolment,</p> <p>OP1a2 Improved human resource education and competencies</p> <p>OP1b1 Health infrastructure developed as per plan and standards</p> <p>OP1b2 Damaged health facilities are rebuilt</p> <p>OP1b3 Improved management of health infrastructure</p> <p>OP2.1 Health services delivered as per standards and protocols</p> <p>OP2.3 Improved infection prevention and health-care waste management</p> <p>OP3.1 Improved access to health services, especially for unreached population</p> <p>OP4.1 Strategic planning and institutional capacity enhanced at all levels</p>	SDG 3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all	Priority 2: Social Development; Priority area 4: Governance, Rule of Law and Human Rights
	Focus area 1.2 National oversight and policy development	<p>OP1c1 Improved procurement system</p> <p>OP1c2 Improved supply chain management</p> <p>OP2.2 Quality assurance system strengthened</p> <p>OP3.2 Health service networks including referral system strengthened</p> <p>OP5.1 Ministry of Health and Population (MoHP) structure is responsive to health sector needs</p> <p>OP5.2 Improved governance of private sector</p> <p>OP5.5 Improved public financial management within MoHP</p> <p>OP6.1 Health financing system strengthened</p> <p>OP6.2 Social health protection mechanisms strengthened</p> <p>OP9.1 Integrated information management approach practised</p> <p>OP9.2 Survey, research and studies conducted in priority areas; and results used making processes at all levels</p> <p>OP9.3 Improved health sector reviews with functional linkage to planning process</p>		Priority 2: Social Development; Priority area 4: Governance, Rule of Law and Human Rights

CCS Strategic Priorities	Focus Areas	NHSS Priorities ²	SDG Targets ³	UNDAF Outcomes
	Focus area 1.3 Coordination, convening and advocacy of partner support for universal health coverage and federalization	OP5.3 Development cooperation and aid effectiveness in the health sector improved		Priority 2: Social Development;
2. Effective delivery of priority public health programmes	Focus area 2.1 Tuberculosis control	OP2.1 Health services delivered as per standards and protocols OP3.1 Improved access to health services, especially for unreached population OP3.2 Health service networks including referral system strengthened	SDG 3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	Priority 2: Social Development
	Focus area 2.2 Elimination of measles, malaria & selected neglected tropical diseases (NTDs)	OP2.1 Health services delivered as per standards and protocols OP3.1 Improved access to health services, especially for unreached population OP3.2 Health service networks including referral system strengthened		Priority 2: Social Development
	Focus area 2.3 Introduction of new vaccines and control of vaccine preventable diseases (VPDs), including combating hepatitis	OP2.1 Health services delivered as per standards and protocols OP3.1 Improved access to health services, especially for unreached population OP3.2 Health service networks including referral system strengthened	SDG 3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all	Priority 2: Social Development

CCS Strategic Priorities	Focus Areas	NHSS Priorities ²	SDG Targets ³	UNDAF Outcomes
	Focus area 2.4 Promoting health through the life course	OP2.1 Health services delivered as per standards and protocols OP3.1 Improved access to health services, especially for unreached population OP3.2 Health service networks including referral system strengthened	SDG 3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births SDG 3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births	Priority 2: Social Development
3. Enhance health security and disaster preparedness and response	Focus area 3.1 Achieve compliance to IHR (2005)	OP8.1 Improved preparedness for public health emergencies OP8.2 Strengthened response to public health emergencies	SDG 3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks	Priority area 3: Resilience, Disaster Risk Reduction and Climate Change
	Focus area 3.2 Detect and respond to public health emergencies	OP8.1 Improved preparedness for public health emergencies OP8.2 Strengthened response to public health emergencies		Priority area 3: Resilience, Disaster Risk Reduction and Climate Change
	Focus area 3.3 Early warning, risk assessment, preparedness and emergency response to disasters	OP8.1 Improved preparedness for public health emergencies OP8.2 Strengthened response to public health emergencies		Priority area 3: Resilience, Disaster Risk Reduction and Climate Change
4. Multisectoral engagement and partnerships for improved health outcomes	Focus area 4.1 Combating antimicrobial resistance (AMR)	OP2.2 Quality assurance system strengthened	SDG 3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks	Priority 2: Social Development

CCS Strategic Priorities	Focus Areas	NHSS Priorities ²	SDG Targets ³	UNDAF Outcomes
	Focus area 4.2 Reducing risk factors for noncommunicable diseases	OP7.1 Healthy behaviours and practices promoted	SDG 3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being SDG Target 3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol SDG 3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents SDG 3.a Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate	Priority area 3: Resilience, Disaster Risk Reduction and Climate Change
	Focus area 4.3 Address the impact of environmental health and climate change	OP7.1 Healthy behaviours and practices promoted	SDG 3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination	Priority area 3: Resilience, Disaster Risk Reduction and Climate Change

² Nepal Health Sector Strategy is available online at: <http://nhsp.org.np/wp-content/uploads/2016/08/NHSS-English-Book-final-4-21-2016.pdf>

³ SDG targets is available online at: http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E

Annex 2: CCS deliverables monitoring/tracking sheet (Sample)¹

To be monitored on annual basis.

Deliverables (full set not provided, see footnote)	2018	2019	2020	2021	2022	Comments/additional information
	Not started	Started (initial phase)	In progress	Completed	At risk	
The basic health package for each level of care is defined and agreed upon, including NCDs, mental health, preventive and promotional activities.						
Easy access to updated standards and treatment guidelines related to the basic health package established						
Monitoring framework of local government health facilities operational						
Tool kit for capacity-building on public health governance and management for local and provincial health ministries developed.						
Annual universal health service coverage report with focus on basic health care at local government level.						
Training packages, specifically geared towards primary level providers published online, regularly expanded and updated.						

Example

¹ WHO Nepal will develop a detailed set of CCS deliverables that will be included in the monitoring /tracking sheet.

Annex 3: Targets to strive for and indicators to measure progress

Area/Level	Indicators	Baseline (Year/source)	Target 2019	2022	Means of verification	Remarks/ comments
Strategic Priority 1: Advancing universal health coverage in a federalized governance structure						
Target 1.1 Strengthen health systems to deliver the basic health package at local government level	Composite coverage index of essential health services	64% (2017, WHO)	70	75	WHO	
Target 1.2 Substantially increase health financing and the recruitment, development, training and retention of the health workforce	Health worker population ratio (per 1000 population)	2.93 (2016 WHO)	4.45	4.45	NHWA/MoH	
	Percentage of out of pocket (OOP) expenditure in total health expenditure	53 (2012, MoH)	45	42	NHA/MoH	Guided by SDG 3 targets
Strategic Priority 2: Effective delivery of priority public health programmes						
Target 2.1 End TB by 2030	Tuberculosis incidence (per 100000 population)	158 (2015, WHO)	142	120	HMIS & WHO	Target guided by TB NSP (2016–2021)
Target 2.2a Sustain polio-free status	Number of wild poliovirus cases	0 (2015–2016, HMIS)	0	0	HMIS	
Target 2.2b Elimination of measles and rubella control by 2019	Coverage of the Measles vaccine	90% (2016, NDHS)	92%	≥ 95%	HMIS, NDHS, NMICS	Disaggregation by local government units
Target 2.2c Elimination of malaria by 2020	Indigenous cases of malaria	506 (2015–2016, HMIS)	-	0	HMIS	
Target 2.2d Eliminate Lymphatic Filariasis by 2020	Microfilaraemia antigenaemia among populations aged older than 5 years	13% (2012, MOH/EDCD)	-	<1%	Survey (MoH/EDCD)	
Target 2.2e Elimination of Kala-azar and Trachoma by 2020	Incidence of kala-azar (per 10 000 population)	0.12 (2016, HMIS)	<0.12	<0.06	HMIS	Disaggregation by province and districts
	Prevalence of trachomatous inflammation follicular (TF) in children 1 – 9 years	-	<5%	<5%	Survey	"
	Prevalence of Trachomatous Trichiasis (TT) unknown to the health system (among adults aged ≥ 15 years)	-	<0.2%	<0.2%	Survey	"

Area/Level	Indicators	Baseline (Year/source)	Target 2019	2022	Means of verification	Remarks/ comments
Target 2.2f Achieve sub-national elimination of Leprosy by 2020	Prevalence of leprosy (per 10 000 population)	0.89 (2016, HMIS)	<1	<1	HMIS	Disaggregation by province and districts
Target 2.3a Eliminating viral hepatitis as a major public health concern by 2030 as a part of SDG. 3.3	Incidence of hepatitis B per 100 000 population	1484 (2015, GBD)	1315	1188	GBD & WHO	
Target 2.4 % of children fully immunized > 90% by 2020 for all wealth quintiles and eco regions	Percentage of children fully immunized	78%	84%	90%	HMIS, NDHS, NMICS	Disaggregated wealth quintiles, local units
Target 2.5 Reduce maternal and child deaths	Maternal mortality ratio	258 (2015, WHO)	125	116	NDHS, WHO	Strengthen MPDSR to get annual statistics
	Neonatal mortality rate	21 (2016, NDHS)	18	16	NDHS, MICS, WHO	Strengthen COD data system to produce frequent/annual statistics
Strategic Priority 3: Enhance health security and disaster preparedness and response						
Target 3.1 Achieve and maintain high level of compliance to IHR	Overall score from Joint External Evaluation	- (TBC in 2018)	TBD (% improvement against baseline)	TBD (% improvement against baseline)	WHO	JEE plan - Baseline in 2018 and Endline in 2022

Area/Level	Indicators	Baseline (Year/source)	Target 2019	2022	Means of verification	Remarks/ comments
Target 3.2 Strengthen institutional capacity to detect and respond to public health emergency	Overall score from SEAR benchmark assessment (BMA) for emergency preparedness and response readiness	- (TBC in 2018)	TBD (% improvement against baseline)	TBD (% improvement against baseline)	WHO	SEAR benchmark assessment planned in 2018.
Target 3.3 Substantially reduce mortality due to public health emergencies	Reduction in annual loss of human life compared to average annual loss between 2005 and 2015 (per 100 000 population)	2.66	2.4	2.16	DRR Portal, MoHA	
Strategic Priority 4: Multisectoral engagement and partnerships for improved health outcomes						
Target 4.1 Optimize the use of antimicrobial medicines in human and animal health	Rate of incidence of AMR for E. coli resistance to 3 rd generation cephalosporin	- (TBC in 2018)	5%	10%	GLASS/ NASS	System to be strengthened
Target 4.1 25% relative reduction in overall mortality from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases by 2025	Probability of dying from any of cardiovascular disease, cancer, diabetes, chronic respiratory disease between age 30 and exact age 70	21.8% (2015, WHO)	19.6%	18.0%	WHO	Strengthen COD data system to produce frequent/annual statistics
Target 4.3 Substantially reduce the number of deaths and illnesses from air and water pollution and contamination	Mortality rate attributed to household and ambient air pollution (per 100 000)	103 (2012, WHO)	95	90	WHO	''
	Mortality rate attributed to exposure to unsafe WASH services per 100 000	12.9 (2012, WHO)	10	8	WHO	''



**World Health
Organization**

Nepal

ISBN 978-92-9022-641-3



9 789290 226413