

Bishnu Poudel for Action Against Hunger



HEALTH SYSTEM STRENGTHENING

PRATAPPUR, DECEMBER 2020



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Office of the Rural Municipal Executive
Pratappur, Nawalparasi (Bardaghat-Susta Paschim)
Lumbini Province, Nepal



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सुनसरी, प्रदेश, नेपाल



PREFACE

Pratappur Rural Municipality always commits for better health and nutrition of its people. The health section of Pratappur Rural Municipality and all health facilities under it have been providing health and nutrition services. We, as the local government have been practicing federal system since last three years. In addition, the constitution of Nepal 2015 recognizes people's right to health care and food/nutrition as a fundamental right. In order to guarantee what the constitution has promised, the health system strengthening exercise was undertaken, which was lead by Pratappur Rural Municipality with the technical and financial support from Action Against Hunger | Action Contre la Faim (ACF). Multiple stages of workshops were conducted wherein learnings from nutrition and health sector including its strengths and weaknesses were analyzed for strengthening the health system of the municipality.

This led to the development of Health System Strengthening action plan, which I believe will guide the development and operation of health and nutrition programme of this rural municipality. Furthermore, I am positive that this action plan will help the health and nutrition activities reach the community level and provide quality nutrition and health services to the people.

Finally, I commit to reflect the proposed activities of health system strengthening action plan into the annual planning and budgeting of Pratappur Rural Municipalities and strongly urge all the relevant bodies and stakeholders working in health and nutrition sector for the implementation and operation of the Health System Strengthening action plan.

अनु कुमारी चौधरी
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Nawalparasi (West of Bardaghat Susta)



Date : 2077/10/25



FOREWORD

With the implementation of federal system in the country, the health sector too like all the other sectors shifted towards federal approach. Thus, decentralized local governments have been providing the health services in the spirit of federalism thereafter. On this ground, in order to strengthen the health system, Pratappur Rural Municipality carried out different stages of health system strengthening exercises under the leadership of health system strengthening steering committee of Pratappur Rural Municipality with technical and financial support from Action Against Hunger | Action Contre la Faim (ACF), where they have identified strengths and weaknesses of the existing health system. These exercises created an excellent opportunity to identify and analyze the bottlenecks, areas of improvement, to sort out corrective measures and develop an action plan for the strengthening of health system of Pratappur Rural Municipality.

Health system strengthening exercises generally tends to Couse on the policy level intervention at the national level. For the first time, we had an opportunity to take on a health system strengthening exercise at the district in Rural Municipality level. The exercise was well and truly lead by HSS steering committee including district level stakeholders. The entire exercise was conducted in two phase which includes diagnosis phase and plaining phase. Due to COVID 19 pandemic the proposed workshops were unable to conduct on time that took almost one year to complete the exercises. One year long exercise outlined five key bottlenecks that will enable the Pratappur Rural Municipality to take action. During the course of exercise five workshops were conducted which is rare opportunity for the all relevant stakeholders of the *Palika* and district to hold rigorous discussion to assess various problems identified in the health system, prioritize them, finalize and assess the key bottlenecks. Hence, I would certainly recommend to do such exercise to other *Palika* as well to develop action plan to strengthen the health system.

Finally yet importantly, I would like to express my gratitude to Action Against Hunger | Action Contre la Faim (ACF) for technical support and thanks to all stakeholders for this valuable contributions.

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A special thanks to the assessment team including HSS technical support from the headquarter (France) Technical Advisor Health System Strengthening: Technical Advisor Sarah Brousse, Health System Strengthening and Regional Health and Nutrition Advisor (Asia): Brigitte Tonon, Regional Health and Nutrition Advisor (Asia); Country Director: Philippe Hamel; Head of Nutrition and Health Department: Sujay Nepali Bhattacharya; Field Managers: Dil Bahadur Khadka and Sher Singh Dahit; Senior Programme Officers: Manisha Katwal, Ranjan Kapali and Shirish Man Singh; and Technical Officers: Bishnu Poudel, Sanjay Kumar Chaudhary and Sujana Silwal. We also express gratitude to Nutrition Supervisors: Amar Pandey and Pashupati Kohar.

Lastly, thankful to all the key informants including Health Workers (HWs) and Female Community Health Volunteers (FCHVs) interviewed during various stages of the exercise.

LIST OF ABBREVIATIONS AND ACRONYMS

ACF	Action Contre la Faim Action Against Hunger
AHW	Auxiliary Health Worker
ANC	Antenatal care
ANM	Auxiliary Nurse Midwife
ASL	Adequate Stock Level
BHSC	Basic Health Service Centre
BHSP	Basic Health Service Package
CBHI	Community-Based Health Insurance
COVID	Corona Virus Disease
CSOs	Civil Society Organisations
CTEVT	Council for Technical Education and Vocational Training
DAG	Disadvantaged Group
DDRC	District Disaster Relief Committee
DHIS	District Health Information Software
EHCS	Essential Health Care Services
eLMIS	Electronic Logistic Management Information System
EOP	Emergency Order Point
EPF	Employment Provident Fund
EPI	Expanded Programme on Immunisation
EWARS	Early Warning and Response System
FCHVs	Female Community Health Volunteers
FGD	Focus Group Discussion
FY	Fiscal Year
GoN	Government of Nepal
HA	Health Assistant

HF	Health Facilities
HFOMC	Health Facility Operation and Management Committee
HI	Health Insurance
HIB	Health Insurance Board
HIS	Health Information System
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HMIS	Health Management Information System
HP	Health Post
HR	Human Resource
HRH	Human Resource in Health
HSIS	Health Sector Information Strategy
HSS	Health System Strengthening
HuRIS	Human Resources Information System
HWs	Health Workers
IEC/BCC	Information, Education and Communication/Behaviour Change Communication
IFA	Iron Folic Acid
IHIMS	Integrated Health Information Management Section
IMAM	Integrated Management of Acute Malnutrition
IMNCI	Integrated Management of Newborn and Childhood Illness
I/NGOs	International/Non-Governmental Organisation
IPD	Inpatient Department
LMIS	Logistic Management Information System
M&E	Monitoring and Evaluation
MGMs	Mothers' Group Meetings
MI	Malaria Inspector
MNF	Municipality Nutrition Facilitator
MSNP	Multi Sector Nutrition Plan
MoF	Ministry of Finance
MoHP	Ministry of Health and Population
MUAC	Mid Upper Arm Circumference
NHEICC	National Health Education, Information and Communication Centre
NHSS	Nepal Health Sector Strategy
NHSSP	Nepal Health Sector Support Programme

NS	Nutrition Supervisor
NPR	Nepalese Rupees
OA	Office Assistant
O&M	Organisation and Management
ORC	Outreach clinic
OPD	Outpatient Department
OOP	Out-of-Pocket
OTCC	Outpatient Therapeutic Care Centre
PHC/ORC	Primary Health Care/Outreach
PHCC	Primary Health Care Centre
PNC	Postnatal care
PO	Programme Officer
PSC	Public Service Commission
RDQA	Routine Data Quality Assurance
RHIS	Routine Health Information System
RRT	Rapid Response Team
RMNCH	Reproductive, Maternal, Neonatal and Child Health
SARI	Severe Acute Respiratory Infection
SBA	Skilled Birth Attendant
SC	Steering Committee
SMART	Specific, Measurable, Achievable, Relevant and Time bound
SSF	Social Security Fund
SSM	Supportive Supervision and Monitoring
ToR	Terms of Reference
TABUCS	Transaction based Accounting and Budget Control System
UMN	United Mission to Nepal
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

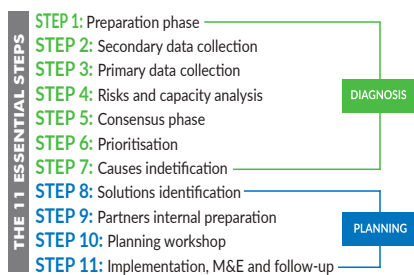
EXECUTIVE SUMMARY

Objective

The objective of this Health System Strengthening (HSS) exercise is to establish a solid collaboration with the local health authorities, to jointly get a snapshot of the health system and understand its strengths and weaknesses at the municipality or *Palika* level, in order to determine the priority actions required for the development of the health system strengthening strategy, that will include building its resilience. This HSS strategy aims at being used by the health authorities from the *Palika* for the development of their roadmap for the coming years.



Structure of HSS methodology



The HSS methodology developed by Action Against Hunger version 3 was used to carry out this exercise under the leadership of the *Palika*, and in collaboration with all the health stakeholders of the *Palika*. The exercise in Pratappur Rural Municipality of Nawalparasi West of Bardaghat Susta district was started in June 2019 and ended in December 2020. The exercise took more time than anticipated because of COVID-19 pandemic. The diagnosis phase intends to provide detailed information on strengths and weaknesses of the health system with regards to the WHO six building blocks i.e. Governance, Financing, Service delivery,

Health workforce, Supply and Health Information System. The planning phase intends to support the development of comprehensive strategies to reinforce the health system based on the initial diagnosis. In addition, an action plan is prepared in order to enable the *Palika* health system to prepare, absorb, adapt and transform from shocks.

Five key bottlenecks

The HSS exercise outlined 5 key bottlenecks in the *Palika* which includes :

- Lack of sufficient, equitable, need and time based Human Resource at health facilities
- Reports generated from Health Information System (HIS) are incomplete and of poor quality and the information is not properly utilised
- Limited essential health services of the continuum of Reproductive, Maternal, Neonatal and Child Health (RMNCH) services available in the health facilities
- Essential health services of the continuum of Reproductive, Maternal, Neonatal and Child Health (RMNCH) services are not utilised adequately by various levels of the health system
- All essential medicines are not present in all health facilities at all time



The HSS strategy



The results of the diagnosis guided the action plan design, which will enable the *Palika* health system to address its bottlenecks and become more resilient to shocks. Under the leadership of the *Palika*, actors of the health system should be mobilised and integrate the activities into their own action plan in order to take HSS action plan forward.

1

HEALTH SYSTEM STRENGTHENING IN THE CONTEXT OF NEPAL



Source: <http://dos.gov.np/nepal-map>

Nepal is governed according to the Constitution, which came into effect on 20 September 2015, replacing the Interim Constitution of 2007. With the new Constitution, Nepal has now adopted a federal system of Governance dividing the country into 7 provinces with 77 districts. Fulfilling the requirement of the new constitution of Nepal, all old municipalities and villages (which were more than 3,900 in number) have been restructured into 753 new municipalities (hereafter referred as *Palikas*). At present, there are 6 Metropolitan Cities (*Mahanagarpalikas*), 11 Sub-Metropolitan Cities (*Upa-Mahanagarpalikas*), 276 Municipalities (*Nagarpalikas*), and 460 Rural Municipalities (*Gaunpalikas*). With this, the health system so far managed centrally has been devolved to the local governance level. In August 2018, the cabinet decided to form 7 Health Directorates in 7 Provinces under the Ministry of Social Development, which has

now been formally established. Following directives from the Federalism Implementation Unit of the Ministry of Health and Population (MoHP), all health facilities (HFs) e.g. Health Posts (HPs), Primary Health Care Centres (PHCCs) with all human resources (HR) and assets have been handed over to the *Palikas*. Though the article 35 of the new Constitution of Nepal has defined the 'right to health' as a basic right, locally elected members (who are basically from non-health background leading the health system) are facing several competing local priorities shadowing importance of health. Many local bodies have failed to procure drugs and medical equipment on time and the essential health services are not being delivered effectively to the beneficiaries seeking services. There is a huge gap of health workforce at local levels, as it is still following the health service delivery structure, developed when Nepal had 10 million inhabitants while it has now

around 28.6 million. The deputed health personnel at the local level (e.g. paramedics at service outlets) are primarily trained to offer health services and lack skills on management and procurement at large. The government has designed and is implementing a decentralised budgeting system however, its effective utilisation remains a big question with the limited capacity the local authorities have. The top-down approach is still seen while designing and implementing many health related projects/programmes. *Palika* governance mechanisms are not yet up and running and informed health strategies can be missing to structure the health system and health services at the health facilities levels. At the same time, local communities do not have a proper place in the governance set-up of the local health facilities and the opportunity to make their voice heard about health services through feedback mechanisms regarding the public health system at the *Palika* level.

The step-by-step approach to carry out a health system diagnosis and planning by Action Against Hunger will put forward the need to have a good governance structure at municipality and health facilities level, using evidence-based approach to develop and implement relevant health planning agenda. Action Against Hunger Nepal has the experience of doing HSS exercise in one of the projects at the district level. However, there has been no such exercise done at the local level (rural/municipalities or *Palika* level engaging locally elected members, who are also leading the health system. In the current context where health is being led by locally elected members, who have limited skills and knowledge of functioning of the health system; strengthening it by prioritising health as a local development agenda is crucial to ensure need based delivery of health services leaving no-one behind.

The Health System Strengthening (HSS) exercise performed at the local level will help to understand better the rural health system structure strengths and weaknesses after devolution, in order to determine the priority actions required for the development of a health system strengthening strategy. This approach aims at building the capacity of local authorities and communities to engage in the health system governance and it will contribute to build health system's resilience by allowing the system to prepare, absorb, adapt and transform from stresses/shocks. Finally, it will allow the documentation of global bottlenecks for the implementation of the decentralised health system approach and help to develop a multi-year costed health action plan.



This approach will provide an overview of the *Palika* health system, based on the six building blocks of the health system defined by the World Health Organization (WHO).

To summarise, the main objectives were to:

- Contribute to strengthening the local health system, through a solid collaboration with the health authorities
- Identify the strengths and weaknesses of the health system at the *Palika* level
- Create a common vision amongst partners at the *Palika* level
- Build a consensus among stakeholders on priority actions to be taken to strengthen the health system
- Introduce the health system strengthening thinking within the *Palika* health planning agenda
- Allow synergy between actors through the development of a multi-year costed health action plan of the *Palika* with clear roles and responsibilities of all relevant actors
- Develop a resilience building approach

2

HEALTH SYSTEM STRENGTHENING: FROM DIAGNOSIS TO PLANNING METHODOLOGY



FROM DIAGNOSIS TO PLANNING
GUIDE
JANUARY 2017



The Health System Strengthening guide is developed by Action Against Hunger. The guide that had its third version published in January 2017 ¹ had its inception in 2010. It was then that Action Against Hunger recognised that most approaches dedicated to assessments of health system are country based- top down model and may not manifest a visible change at the district and *Palika* level. Hence, this guide adopts a bottom up approach to carry out a health system diagnosis and development of health system strengthening strategies, at *Palika* level. The first version of the guide was published in 2013 followed by a second version in early 2015. In January 2017, a third

version of the guide was released. The global Nutrition Cluster has endorsed the methodology. The guide takes an adaptable approach. It can be adapted to the context and situation of the health system of particular country or sub-region, since it aims at strengthening existing mechanisms. Hence, it focused on the process and not the model. The HSS exercise was done in a participatory approach where a Steering Committee (SC) was locally formed to lead the whole process. The SC comprised of Chair of the *Palika* leading the committee along with key stakeholders working in the *Palika*. The roles of the SC was to adapt the methodology to the context, setting up tools, engage all stakeholders actively in each steps of the process and to ensure that the developed action plan are implemented, monitored and followed up. Action Against Hunger facilitated the entire exercise and discussion with relevant stakeholders within the *Palika* building a common consensus. A multi-year costed health action plan was developed for the *Palika* which was endorsed by the Steering Committee.

During the diagnosis phase, COVID-19 pandemic led to disturbance in continuation of the HSS exercise. Hence, the exercise took longer time than anticipated.

2.1 STRUCTURE OF THE HSS METHODOLOGY

The main actors involved in the HSS methodology, are generally all those who contribute to the function of the health system at the *Palika* level. It is important to have a clear understanding of the roles and responsibilities of each actor within the health system before setting up the HSS exercise. It is very vital to conduct the entire HSS exercise under the leadership of the local authority to take ownership and operationalise the action plan developed. The approach comprises of 2 phases and 11 steps. It is

¹ Health System Strengthening: From diagnosis to planning, Action Against Hunger, 2017
<https://www.actionagainsthunger.org/publication/2017/03/health-system-strengthening-diagnosis-planning>

followed by an implementation phase, where the health authorities are in charge of the implementation of the HSS roadmap. The two phases are:

The diagnosis phase intends to provide detailed information on strengths and weaknesses of the health system with regards to the WHO six building blocks of the health system namely Governance; Financing; Service delivery; Health Workforce; Supply; and Health Information System. A literature review and analysis of primary data collection allow to adopt an evidence-based approach. A set of workshops, allows discussions

involving actors of the various levels of the health system, and ultimately creating a synergy of action.

The planning phase intends to support the development of comprehensive strategies to reinforce the health system based on the initial diagnosis. In addition, resilience oriented activities/approaches are identified in order to enable the health system to prepare, absorb, adapt and transform from predictable or exceptional small medium or large shocks. The following table further subdivides the two phases into steps.

Table: Short description of the activities in each step of HSS

Step	Description	Actions
Diagnosis phase		
1	Preparation phase	<ul style="list-style-type: none"> A Steering Committee (SC) is created and terms of reference of the SC is defined. Main characteristics of the methods are defined.
2	Secondary data collection	<ul style="list-style-type: none"> Secondary information regarding each building block and the context is collected.
3	Primary data collection	<ul style="list-style-type: none"> Primary information regarding each building block is collected at the <i>Palika</i> level. Secondary and primary information are analysed.
4	Risks and capacity analysis	<p>Through a participatory approach:</p> <ul style="list-style-type: none"> Risks (type 1 and 2 shocks) and capacities are identified at the <i>Palika</i> level. <i>Palika</i> thresholds are defined based on the workload and capacity of the <i>Palika</i>.
5	Consensus phase	<p>Through a participatory approach:</p> <ul style="list-style-type: none"> The data previously collected are final-analysed The health system is assessed, by scoring benchmarks of each building block. The main strengths and weaknesses of the health system are highlighted.
6	Prioritisation	<p>Through a participatory approach:</p> <ul style="list-style-type: none"> List of prioritised bottlenecks of the health system are outlined.
7	Cause identification	<p>Through a participatory approach:</p> <ul style="list-style-type: none"> Interrelated causal trees of the prioritised indicators are built. Immediate, underlying and basic causes are identified.
Planning phase		
8	Solutions identification	<ul style="list-style-type: none"> Solutions trees are built. 'HSS objectives' are identified for each solution.
9	Partners internal preparation	<ul style="list-style-type: none"> The planning method is well understood by the partners. Activities for the planning phase are pre-identified.
10	Planning workshop	<p>Through a participatory approach:</p> <ul style="list-style-type: none"> A multi-year health action plan along with cost and resources is developed.
11	Implementation, M&E and follow-up	<ul style="list-style-type: none"> External communication is performed. A new adjusted Steering Committee is created. Implementation, M&E plans are developed.

3

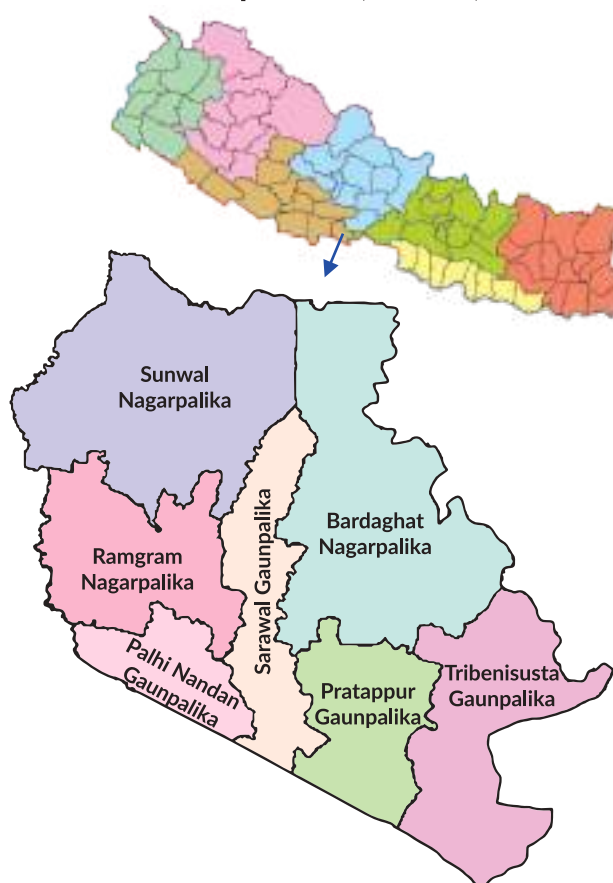
DIAGNOSIS PHASE

First, with the perspective of ensuring a participatory approach, Action Against Hunger briefed the Chair of *Pratappur* Rural Municipality (*Palika*) about the HSS exercise, including its rationale, objective and importance. After getting consent from the Chair of the *Palika*, Action Against Hunger team approached the Health Office of Nawalparasi West of Bardaghat Susta district and other stakeholders working in the rural municipality. After discussion with different stakeholders, Terms of Reference (ToR) for the Steering Committee (SC) along with proposed members for SC under the leadership of Chair was defined. The ToR included the below key roles of the SC:

- The Chair (Co-chair in absence of the Chair) to call regular meeting of the SC
- Based on the context of *Palika*, adapt/modify/adjust global methodology of the HSS, if needed
- Review results obtained during the exercise
- Approve work plan and results of the exercise
- Participate in each step of the exercise
- Prepare list of participants for different meetings/workshops
- Summarise outcomes of the meetings
- Inform all relevant stakeholders on results obtained through different steps of the HSS exercise

Following federalisation, the health system is yet to become a stable structure, hence it was decided to nominate members of the Steering Committee as per position within the Organisation and not individuals. The composition of the SC was as follows:

Map of Nepal showing Nawalparasi West of Bardaghat Susta district and Municipalities (Palikas)

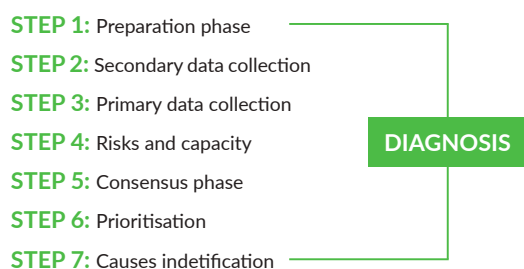


Source: https://en.wikipedia.org/wiki/Pratappur,_Nepal

Table: Short description of the activities in each step of HSS

S.N.	Position in SC	Organisation	Position in the Organisation	Remarks
1	Chair	Pratappur Rural Municipality	Chair	
2	Co-chair	Pratappur Rural Municipality	Co-chair	After death of the Chair, Co-chair became the Chair of the SC.
3	Member Secretary	Pratappur Rural Municipality	Health Coordinator	
4	Member	Pratappur Rural Municipality	Chief Administrative Officer	
5	Member	Pratappur Rural Municipality	Deputy Health Coordinator	
6	Member	United Mission to Nepal (UMN)	Programme Coordinator	INGO
7	Member	Indreni Development Forum	Programme Coordinator	NGO
8	Member	Health Mothers' Group, Ward - 9	Chair	Did not show up for multiple SC meetings, hence removed from the SC by the Chair
9	Member	Action Against Hunger, Nawalparasi	Sr. Programme Officer	

The Chair of the SC formally appointed all the members of the committee. Following this, secondary and primary



data were collected, which allowed to analyse and understand the context and the health system. In the diagnosis phase, two workshops took place with the key stakeholders of the *Palika* to, first identify the shocks and risks to which the health system is exposed; and then to assess in details the *Palika* health system through scoring of indicators and the analysis of the causes of the main bottlenecks. The diagnosis involved a total of 7 out of 11 steps in respect to Action Against Hunger’s HSS methodology. A brief description of the two workshops of the diagnosis phase are as follows:

- Workshop 1 - Risk and capacity (Step 4): The workshop was conducted to identify and analyse the type 1 & 2 shocks to which the *Palika* is exposed, reflect the capacity of the *Palika* to cope with shocks, define thresholds for the *Palika* to indicate normal to emergency situations.

- Workshop 2 – Diagnosis workshop (Steps 5-7): The workshop provided an opportunity for a thorough assessment of the health system, by scoring indicators of each building blocks, prioritise the main bottlenecks of the health system; describe and analyse the causes of the prioritised bottlenecks, and identify the HSS objectives and describe the solutions.



Photo: Direct observation of store in Pratappur Health Post

3.1 DATA COLLECTION AND INDICATOR SCORING

Prior to data collection, an orientation on HSS was held on 28 August 2019. The orientation was given to all the SC members about the HSS exercise, its methodology and importance. In order to benefit from an evidence-based approach, primary and secondary data were collected to properly inform the discussion during the workshops. Secondary data was collected, especially through available literature reviews. Primary data was collected in all existing health facilities from the *Palika*, and information was gathered on the WHO six building blocks i.e. service delivery, health workforce, health information system, supply, financing and governance. All questionnaires for primary data collections were adjusted as per the local context, translated into Nepali and endorsed by the SC before data collection. The primary data was collected in the health facilities, using three different techniques:

- Direct observations
- Individual interviews
- Focus Group Discussions (FGDs)

The data collection took place in all the existing health facilities within the *Palika* viz. Health Posts (HPs) and Primary Health Care Centres (PHCCs). In total, there are one Primary Health Care Centre and six HPs in the *Palika*:

Table: List of health facilities for primary data collection

S.N.	Name and type of health facilities
1	Jaganathpur PHCC
2	Baidhauri HP
3	Thulo Khairatwa HP
4	Pratappur HP
5	Guthi Parsauni HP
6	Guthi Suryapura HP
7	Somani HP

The information generated from the primary and secondary data as well as knowledge and experiences of the stakeholders of the *Palika* health system were used to score a self-assessment tool during the diagnosis workshop. Scoring was established through discussions and consensus between all the various actors of the *Palika* health system. The self-assessment tool consisted

of 113 indicators used to score each building block to assess the present state of the *Palika* health system. A list of indicators suggested by the HSS guide was adapted to the local context. For each indicator included in the tool, a range of possible scenarios was provided allowing for an objective and quantitative ratings from the highest score to the lowest one. The highest score, 3, was given for scenario considered as highly adequate compared to a gold standard. A score of 2 for a scenario considered as adequate and subsequently score of 1 for a scenario considered as present but not adequate and 0 for a situation regarded as not adequate at all. The assessment of each indicator in a building block contributed to scoring the entire block as follows:

Colour code for the scoring of the indicators	Interpretation
2.25 to 3.0 (75%-100%)	Highly adequate
1.5 to 2.24 (50%-74%)	Adequate
0.75 to 1.49 (25%-49%)	Present but not adequate
0 to 0.74 (0%-24%)	Not adequate at all



Shirish for Action Against Hunger

Photo: Individual interview for primary data collection

Shock Analysis

3.2 RESULTS OF THE DIAGNOSIS

Health system resilience can be defined as the capacity of health actors, institutions, and populations to prepare for and effectively respond to crises; maintain core functions when a crisis hits and informed by lessons learned during the crisis, reorganise if conditions require it.² Response to a crisis, disease outbreak or disruption of service delivery, results in a surge of demand for health care and a functioning health system. As Nepal is going through the process of decentralising its system of governance, the health system is more fragile. Hence, resilient health system will mitigate adverse health effects and continuation of service delivery in both normal and emergency situations. Building resilience is context-dependent needing assessment of system capacities and response. Following this, a workshop for risk and capacity analysis of the health system and defining the threshold was conducted with local authorities and relevant stakeholders from the *Palika*. An assessment of the situation to build resilience, threshold for different health facilities and overall *Palika* was identified at the end.

3.2.1 TYPE 1 AND TYPE 2 SHOCKS

TYPE 1 SHOCKS

Type 1 shocks induce a caseload increase. They are surges, and are rise in the number of admissions regardless of the cause, the rapidity and the length of the rise. It can be seasonal admission peaks as well as the result of a natural disaster for instance. These important influx of patients tend to stretch a lot the functionalities of the health system and challenge its resilience capacities, embedded in the six building blocks.

To assess the ability of the health facilities to prepare and face type 1 shocks, data regarding the caseload fluctuations of the *Palika* (including both HPs and PHCC), were collected and discussed during workshop 1. The data available were for the fiscal year 2074-76 (2017-2019 AD) prior to COVID-19 pandemic. For the PHCC caseload, patients (all age range and gender) coming to the outpatient and emergency were considered.

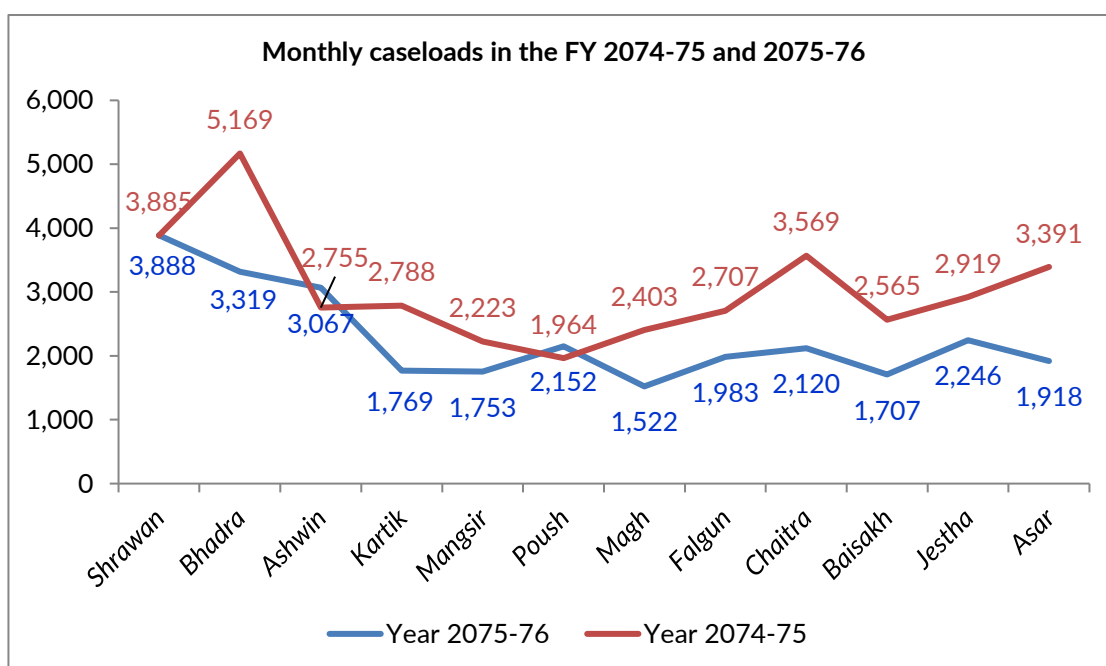


Figure: Monthly caseloads in two fiscal years (2074-2076) in *Pratappur* rural municipality

The caseload information showed that the number of cases peaked during a few months in both the fiscal year however, there was high discrepancies in few months. The caseload was high in the months of *Asar* to *Bhadra* and subsequently low in the months of *Ashwin* and *Kartik*. The increase in the caseload during *Asar* to *Bhadra* is mainly due to rainy season when water borne diseases is seen. Subsequently, in the following month the number has drastically decreased as the major festivals

i.e. *Dashain* and *Tihar* falls in these months, with more food availability and beneficiaries reluctant to visit health facilities.

The main diagnosis were:

- Other diseases and injuries mostly related to fever of unknown origin and headache

2 What is a resilient health system? Lessons from Ebola; Lancet 2015; 385: 1910-12

- Communicable water borne diseases are mostly represented by diarrhoea cases. The prevalence of the cases goes up during rainy season when water sources are more likely to be contaminated, and the hygiene practices are poor.
- The data from the last two fiscal years 2074-76 showed that the top disease in *Pratappur* was diseases and injuries (Pyrexia of Unknown Origin) with an average caseload of 2,840 in 2 FYs; followed

by headache and surgical problems. According to the available data, other prominent morbidity in the *Palika* were diarrhoea, musculoskeletal pain, Upper Respiratory Tract Infection, scabies, gastritis etc.

- The caseload information from the secondary analysis found that the average total number of cases is 31,891 per year, with an average of maximum 4,244 cases per month.

DEFINING THRESHOLD

Thresholds are a number of monthly new cases observed at the health facility level regardless of the diagnostic, and represent the point at which the rural municipality is overstretched beyond its capacity and requires action in order to cope with the situation. They take into account both the capacity of the health facility and the workload of the *Palika*: when the workload surpasses the capacity, this is the ideal value to set a threshold. Each threshold defines a phase. The threshold system allows the *Palika* to prepare and cope with surges, monitoring of the new cases and a comparison to establish thresholds. It is to encourage each health facility and the *Palika* to identify in advance what should be the priority of each phase, as well as the related activities, in order to help them get prepared for such surges in the activities. These thresholds should help the *Palika* and HFs to better prioritise the activities to be carried out during each of the phases.

Thresholds have been defined in order to identify four different phases i.e. normal, alert, serious and emergency, which describe the various situations in which the *Palika*

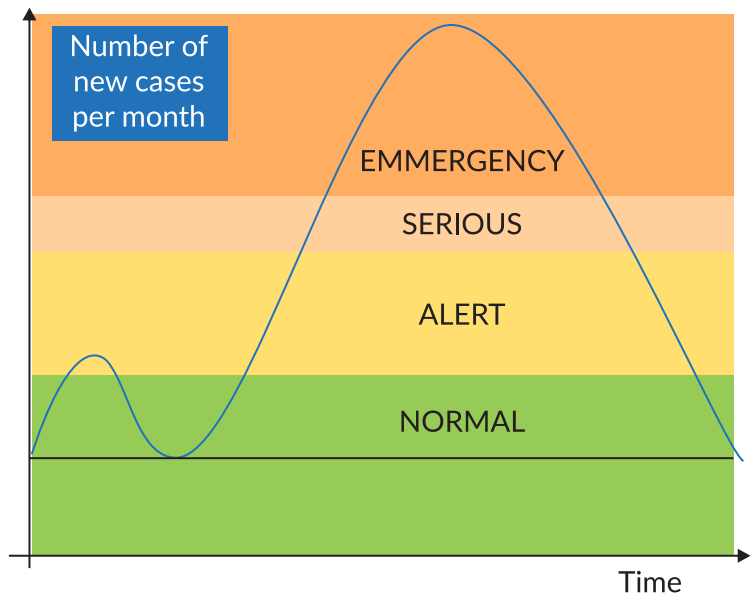


Figure: Thresholds monitoring over a period of time

could be. These various phases will help the *Palika* to get better organised for type 1 shocks. The thresholds were calculated, for both HPs and PHCC assuming 25 working days per month with working time from 10:00 am to 05:00 pm daily,

Table: Thresholds for various health facilities (number of monthly new cases)

	Threshold 1 (Normal/Alert)	Threshold 2 (Alert/Serious)	Threshold 3 (Serious/Emergency)
Health Post - 6	1,625	2,500	3,750
Primary Health Care Centre - 1	1,750	3,000	5,000
<i>Palika</i>	11,500	18,000	27,500

TYPE 2 SHOCKS

Type 2 shocks not necessarily induce a caseload increase. The intrinsic structure of the system (the 6 pillars) is disrupted by an event, which provokes a dysfunction of the system itself. However, a rise of caseloads is not

necessarily observed. For instance, a flood would prevent drugs and materials to be delivered to the health facility. The following calendar of type 2 shocks has been agreed on, based on the results from the primary data collection and the discussions during the workshop 1. Shocks are described as well as the effect they have on the HF as well as the magnitude of shock:

Table: Thresholds for various health facilities (number of monthly new cases)

Months		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
		Shrawan	Bhadra	Ashwin	Kartik	Mangsir	Poush	Magh	Falgun	Chaitra	Baisakh	Jestha	Asar
Type 2 shock		Flood	Flood	Festival	Agricultural work load, festival	Agricultural work load	Cold wave	Cold wave	Storm	Excessive heat, storm	Excessive heat, storm	Excessive heat, agricultural work load	Flood, excessive heat, agricultural work load
Effects		Service delivery, Financing, HR, Logistics, HIS	Service delivery, Financing, HR, Logistics, HIS	Service delivery, Financing, HR, Logistics	Service delivery, Financing, HR, Logistics	Service delivery	Service delivery	Service delivery	Service delivery	Service delivery	Service delivery	Service delivery	Service delivery, Financing, HR, Logistics, Information management, HIS
Shock magnitude (High (3) / Medium (2) / Low (1))		2	2	1	1	1	1	1	1	1	1	1	2

Pratappur being a flood prone area, access to health facilities during rainy season is difficult. There is difficulty for the service seeker and service provider both to reach the health facilities. Also, transportation of supplies especially medicines and other health equipment is a challenge because seasonality is not considered to maintain stock of supplies and medicines in the health facilities. This will have an impact on interruption of regular supply chain. During agricultural season, the workload is high in the household including health workers providing services in the health facilities and

during festive season people are travelling to different places resulting in low case flow in the health facilities. During this period, service delivery will be negatively impacted. Access and transportation is still a problem during excessive heat and storm resulting in affecting service delivery.

The different Type 2 shocks identified during the workshop and its ranking as per severity of adverse effects are as follows:

Table: Identified Type 2 shocks and its magnitude over a year time period

Month/Type of shock	Excessive heat	Flood	Cold wave	Festival	Agricultural workload	Storm
Jul (<i>Shrawan</i>)		2				
Aug (<i>Bhadra</i>)		2				
Sep (<i>Ashwin</i>)				1		
Oct (<i>Kartik</i>)				1	1	
Nov (<i>Mangsir</i>)					1	
Dec (<i>Poush</i>)			1			
Jan (<i>Magh</i>)			1			
Feb (<i>Falgun</i>)						1
Mar (<i>Chaitra</i>)	1					1
Apr (<i>Baisakh</i>)	1					1
May (<i>Jestha</i>)	1				1	
Jun (<i>Asar</i>)	1	2			1	

Leadership and Governance

3.2.2 LEADERSHIP AND GOVERNANCE

Leadership and Governance in a health system involves ensuring that strategic policy frameworks are in place and are combined with effective oversight, coalition-building, regulation, attention to system design and accountability. Accountability is an intrinsic aspect of governance that concerns the management of relationships between various stakeholders in health, including individuals, households, communities, firms, governments, nongovernmental Organisations, private firms and other entities that have the responsibility to finance, monitor, deliver and use health services.³

Updated National Health Policy, 2019 guides Nepal's health system. The new health policy aims to create opportunities for all citizens to use their constitutional rights to health; develop, expand and improve all types of health systems as per the federal structure; improve the quality of health services delivered by health institutions of all levels and to ensure easy access to those services;

strengthen social health protection system by integrating the most marginalised sections; promote multi-sectoral partnership and collaboration between governmental, non-governmental and private sectors and to promote community involvement; and transform the health sector from profit-orientation to service-orientation.⁴ Further, Nepal Health Sector Strategy (2015-2020) aims to guide the health system towards Universal Health Coverage, and assure equitable access to quality health services for the population.

Previously the health facilities were accountable to various units of MoHP but following local election in May and June 2017 after a gap of 20 years, the *Palika* has begun exercising rights and duties and operationally the basic health services including the institutions delivering those services have come under them. The responsibility to conduct nutrition programme at the local level also comes under the jurisdiction of the local government i.e. *Palika*.

³ World Health Organization, 2010: *Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies*.

⁴ Annual Report, Department of Health Services, 2075/76

Organisational structure – Pratappur Rural municipality

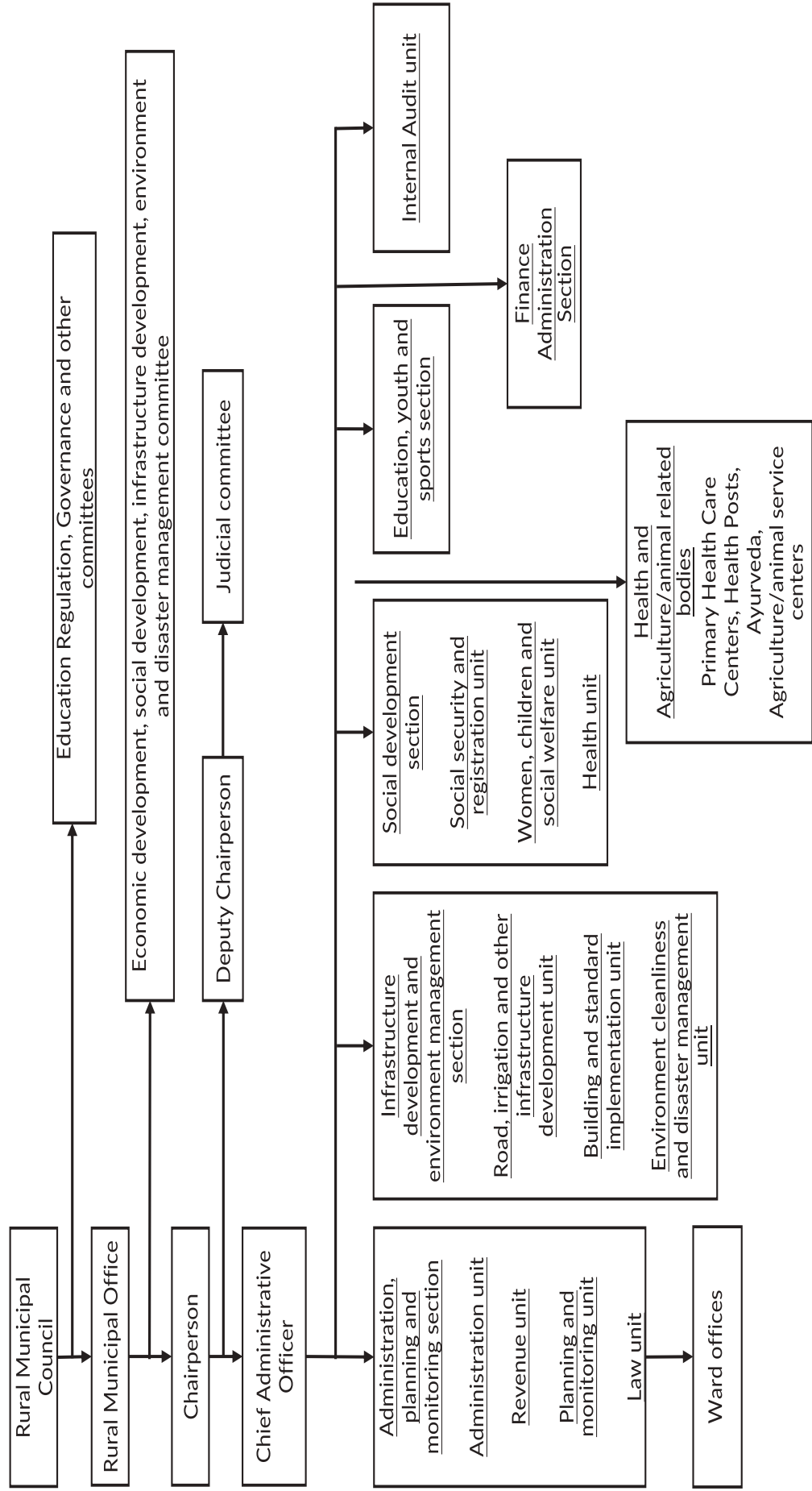


Figure: Organogram of Pratappur rural municipality

In context of district health system the responsibility of imparting basic health services has devolved to the *Palika*. The former district hospitals are either under provincial or under federal government based on the number of beds in the hospital. The health offices are accountable for providing technical support to the health coordinators and the health facilities, and also to support in the supply chain management within the district.

RESULTS OF LEADERSHIP AND GOVERNANCE

The strengths and weaknesses for governance was captured based on the primary data collection that included direct observation, Key Informant Interview and Focus Group Discussion administered to different key stakeholders (service seeker and provider both).

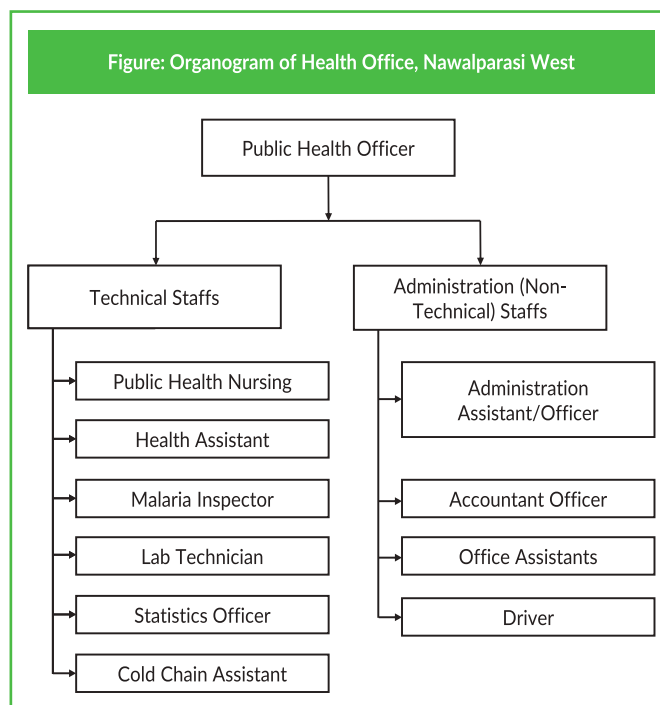


Table: Strengths and weaknesses of Governance building block in Pratappur

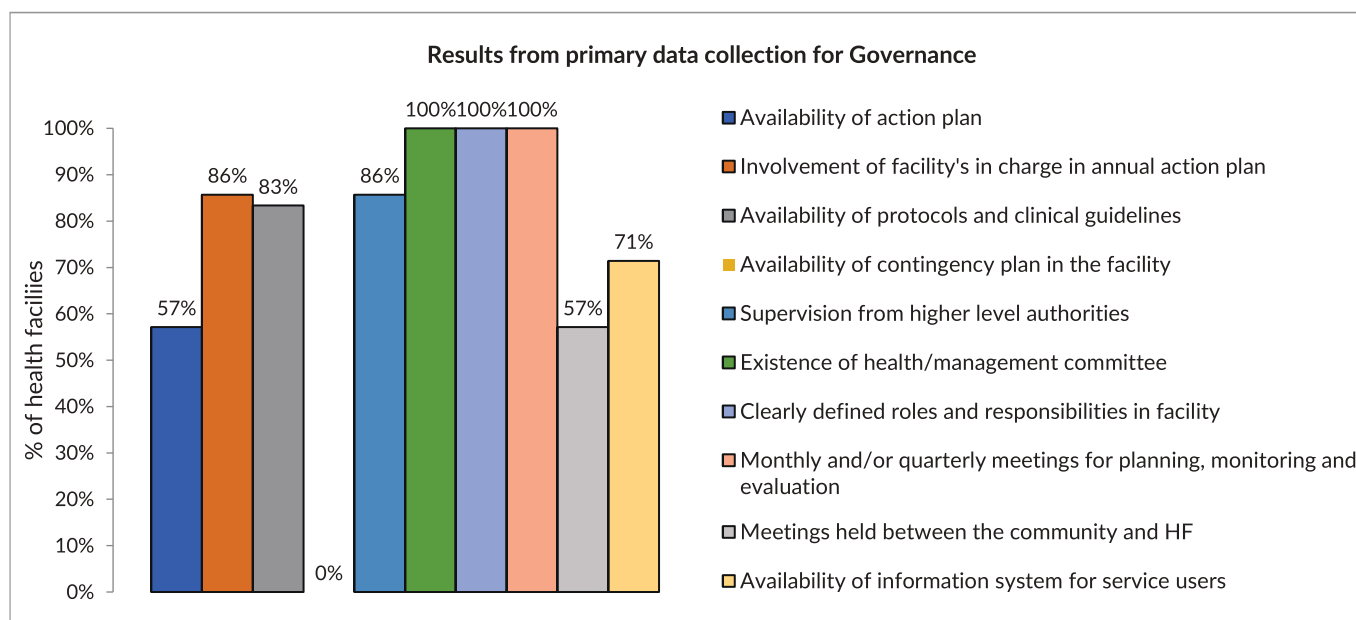
Strength	Weakness
<ul style="list-style-type: none"> ▪ Existence of Health Facility Operation and Management Committee (HFOMC) in all HFs ▪ Clearly defined roles and responsibilities of all health workers in the health facilities ▪ Regular meetings held for planning, monitoring and evaluation e.g. existence of monitoring and supervision committee chaired by <i>Palika</i> ▪ Availability of protocols and clinical guidelines in all health facilities (available in 83% of the HFs) ▪ Coordination with District Disaster Relief Committee (DDRC); Rapid Response Team activates to respond during emergency ▪ Financial resources coming from donors/partners for interventions are harmonised/coordinated by the <i>Palika</i>. ▪ No difficulties in programme implementation by I/NGOs (<i>Palika</i> is welcoming for support from the I/NGOs) ▪ Involvement of health facilities' in charge in annual action plan of the <i>Palika</i> (available in 86% of the HFs) ▪ Good coordination between the <i>Palika</i>, HWs and FCHVs and regular dissemination of information 	<ul style="list-style-type: none"> ▪ Unavailability of annual action plan in majority of the HFs ▪ Unavailability of contingency plan during emergency ▪ No regular monitoring and supervision done from different levels (Health Office, <i>Palika</i>, Province, Federal level) ▪ No meetings held between the community and the HF (57% of HFs reported no meetings) to share about the programme or feedback/complaint on services ▪ No exit plan prepared by actors (I/NGOs) in consultation with local authorities/government before exiting the <i>Palika</i>; only handover meeting conducted ▪ No mapping of actors (I/NGOs) working in health sector at the <i>Palika</i> level ▪ Unavailability of Focal Persons for specific programmes (e.g. Nutrition, Tuberculosis etc.) at the <i>Palika</i> level and HFs due to ongoing adjustment/transfer of health staffs ▪ Unavailability of information system (Citizens' charter) for service users in the HFs (Only 29% of the HFs have it) ▪ There is no mechanism set to receive feedback and complain from community, Health Workers (HWs), FCHVs, beneficiaries etc.

During the diagnosis workshop, the governance building block obtained a score of “Present but not adequate”, with a score of 1.25 out of 3. The scoring of the Governance shows that the regulations framework is present but not adequate at the national and *Palika* levels, and on top the challenges in the implementation and accountability of this governance framework still remains. The main policies, regulations, strategies and plans are developed by the federal level and disseminated up to the *Palika* and HF levels for implementation.

A pre-defined organogram is available, however due to restructuring/staff adjustment, clearly defined roles and responsibilities have been reshuffled and partially applied. An annual work plan and budget is developed and implemented by the *Palika* authorities, and the national protocols, tools and guidelines for nutrition and health are all formulated by the federal level, and are disseminated in the other levels of the health system (district and beyond). It was also found that only 57% of the health facilities have annual action plans. In those facilities where the plan is present, the implementation itself is not properly done due to a lack of execution strategy. Moreover, a policy and a multi-sectorial strategy on the prevention of child illnesses and malnutrition (Multi-Sector Nutrition Plan) are developed at the federal level and an action plan is implemented by the *Palika*, although MSNP structures at the *Palika* level is not active. All the health programmes are led by the *Palika* and all health facilities are under monitoring and supportive supervision of the *Palika*, which is not regular and effective. Supervision and monitoring from the Health Office, Provincial and federal levels are not regular with no feedback for corrective actions.

Governance		1.25
1	Policy formulation and planning	1.50
2	Information/assessment capacity	1.00
3	Social participation and system responsiveness	0.88
4	Accountability	1.20
5	Regulation	2.00

There is contingency plan at the *Palika* level but there is no emergency response plan at the health facility level. Rapid Response Team (RRT) of the health facility works in coordination with District Disaster Relief Committee (DDRC). In limited health facilities (57%) only, there is action plan available but the communities and the stakeholders are not engaged in formulation of the action plan. Annual reports are developed but there is no strategy to disseminate it to wider stakeholders including public. Any programmes commenced by the donors and partners are aligned with the National Health Sector Support Plan (NHSSP) and Multi-Sector Nutrition Plan (MSNP, 2018-2022) however, collaboration with Civil Society Organisations (CSOs) can be further strengthened. Relevant partner agency working in the *Palika* have an exit plan of conducting handover meetings.



Graph: Summary of results of primary data for Governance

An annual work plan and budget is developed and implemented by the *Palika*, however meetings and planning session related work are not held regularly. Lessons learned are not capitalised for corrective actions and only findings are shared during annual review but not shared with wider community. There is a clear and comprehensive strategy of IEC/BCC developed at the federal level by National Health Education Information and Communication Centre (NHEICC). However, this strategy is not well rolled out at the *Palika* level.

The roles and responsibilities of all health personnel involved in the health system are clearly defined, but it is not always implemented correctly. An annual report is produced by the *Palika* on the performance of the health sector, but the report is not broadly disseminated. Beside there is no provision and publication of guidance on the prioritisation of the *Palika's* health expenditures based on resource availability and health needs assessment. Regulations on standard for infrastructures and equipment, safety, efficacy and quality of drugs are available.

Financing

3.2.3 FINANCING

Health financing is fundamental to the ability of health systems to maintain and improve human welfare.⁵ It is a core function of health systems that can enable progress towards Universal Health Coverage by improving effective service coverage and financial protection. Health services delivered by the federal MoHP and by provinces and Palikas (including general health services and others such as the Safe Motherhood Programme, the Free Health Care Programme, the Basic Health Care Package service, and the Impoverished Citizens' Service Programme) are mostly funded by taxes, but contributions also come from external donors (both pooled into the public budget). The participation of external funds in the public revenue-collecting mechanisms decreased from 50% to 14% from 2000 to 2016. These sources are complemented by user-fee charges paid as OOP (Out Of Pocket) by families when the public health services are delivered by the health facilities. OOP is the principal source of health financing in Nepal, contributing more than 55% of Current Health Expenditures, followed by Public Health Expenditure (19%), Health Insurance (14%), and external expenditures (12%) in 2016. High OOP payments bring the risk of catastrophic health expenditures and families' impoverishment. Recent research shows that households with a higher number of children under age five years and of elderly persons are more likely to incur catastrophic health expenditures

in Nepal. In 2016, the highest share of health spending in Nepal was used to purchase goods (medicines and supplies), representing 36% of Current Health Expenditures, followed by curative services (32%) and preventive services (18%). The main revenues for Health Insurance (HI) in Nepal are i) contributions (premiums) collected from members with ability to pay and ii) tax funds provision, financed by the Ministry of Finance (MoF), as annual block grant directed to the health insurance fund to subsidise premiums for the poor, senior citizens and to cover the health insurance administrative expenses. The national HI, which is slowly in implementation process has allocated US\$5.3 million for fiscal year 2018/19 through MoF to subsidise premiums to the poor. The health insurance previewed under the Social Security Fund (SSF) is not yet implemented. However, both HI and SSF will count on tax-based subsidies and premiums paid by enterprises and enrolees, when defined by specific legislation. However, the full implementation of the national HI might face delays because there is no effective mechanism for identifying the poor.⁶

RESULTS OF FINANCING

The strengths and weaknesses for financing was captured based on the primary data collection that included Direct Observation, Key Informant Interview and Focus Group Discussion administered to different key stakeholders (service seeker and provider both).

Table: Strengths and weaknesses of Finance building block in Pratappur

Strength	Weakness
<ul style="list-style-type: none"> ▪ Health facilities receive funding envelope from the <i>Palika</i> to deliver basic health services. ▪ There is availability of other funding sources (Red book and other) to the <i>Palika</i> for health services. ▪ There is presence of person in charge of the fund management within the HF, who is the HF In charge. ▪ Presence of free care policy in HFs ▪ Regular audit of the expenses done in health by the <i>Palika</i>. 	<ul style="list-style-type: none"> ▪ Allocated funds to the health facilities by the <i>Palika</i> is not sufficient for basic health service delivery. ▪ There is no sufficient finance and process to deal with Type 1 and Type 2 shocks at the <i>Palika</i> level. ▪ There is no solidarity fund for the most deprived/ poor people at the <i>Palika</i> level. ▪ There is no involvement of community in the financial management of the HF. ▪ Budget allocation is not done based on priority of the programme. There is no analysis of the need for each programme.

The financing building block acquired a score of 1.58 out of 3 meaning that it is adequate. There are funding coming from government and donors, however these funds are not sufficient. In addition to this, activities are not developed as per priority and budget availability. There is no system of basket fund and hence there is need to have more coordinated and systematic

financial mechanism in place. Since the *Palika* is mostly implementing the activities defined and budgeted, an analysis of financial gap is not performed. However, there is a system called Transaction based Accounting and Budget Control System (TABUCS) which allows to record all financial activities and can be used to do gap analysis. There is no system of joint financing the government and

⁵ World Health Organization, 2010: Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies.
⁶ Government of Nepal, Ministry of Health and Population. 2019. SITUATION ANALYSIS OF HEALTH FINANCING IN NEPAL. MoHP, World Bank, WHO, GIZ, Kathmandu, Nepal.

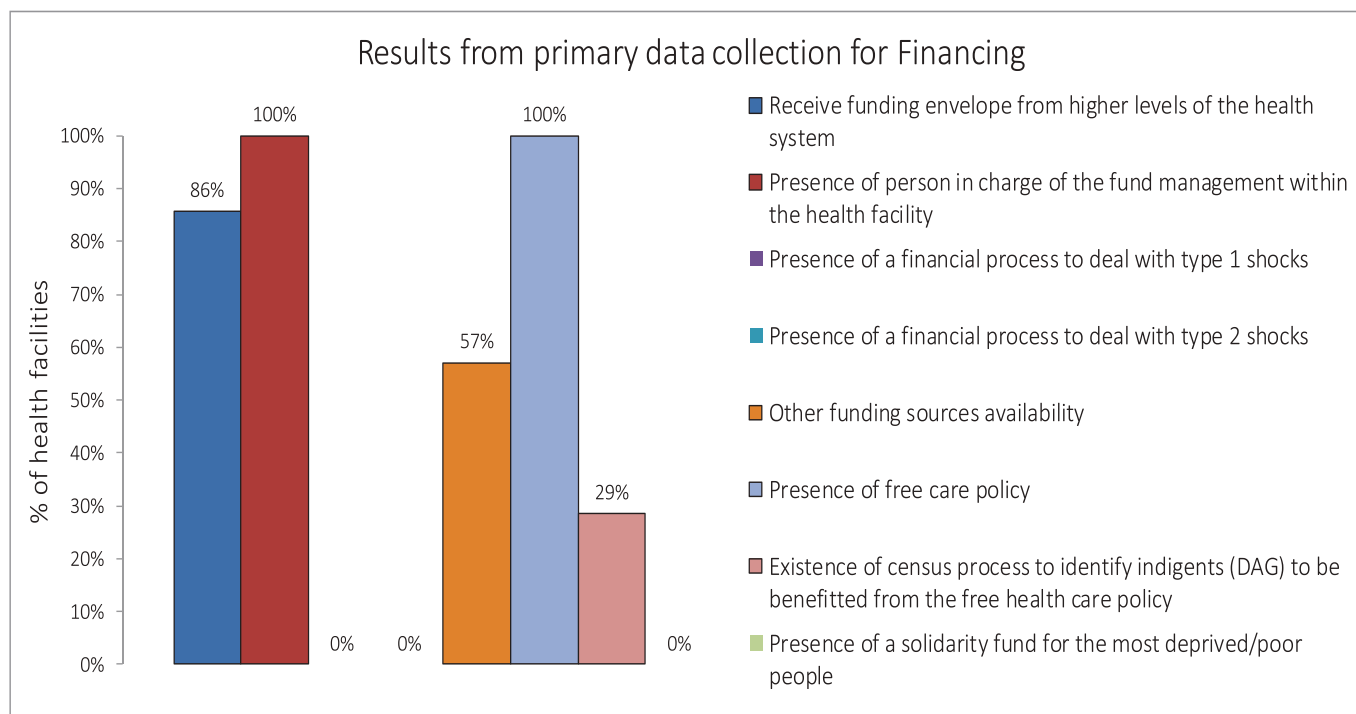
different Organisations working in same intervention area for same outcome. It was observed that there was no pooling of resources taking place, budgeting of activities was done individually by donors, local NGO or any other actors working in the same intervening area. However, duplication of activities have been avoided in coordination and communication with the partners. Budget are allocated for annual activities of the *Palika* and the budget are insufficient and short termed. The annual plan are not developed as per programme priority and budget hence are not allocated per priority either. Regular activities of RMNCH are getting funds however, no new activities are developed or planned and the funds are also not sufficient for existing activities. No funds are allocated to the *Palika* health authorities dedicated and sufficient for preparing and coping with shocks 1 and 2. The *Palika* finance management is often on ad hoc basis during emergencies, budget explored and allocated as and when required.

Table: Results for the Financing building block

Financing		1.58
6	Pooling and allocation of financial resources-Government budget formulation and allocation	1.75
7	Joint financing	1.00
8	Universal access to health care	2.00

The *Palika* releases fund to all health facilities and HFOMC manages the fund for the health facilities. The budget released by the *Palika* is not adapted and balanced according to areas for instance, rural and urban. The cost exemption policy is applied in the various health facilities for categorised diseases (cancer, kidney etc.) as per need to ensure a broad financial access to care for all the general population but there is no dedicated fund allocated for Disadvantaged group (DAG).

The coverage, eligibility, financing, and managerial mechanisms for health programmes and health insurance schemes in Nepal is given in annex.



Graph: Summary of results of primary data for Financing

Human Resources

3.2.4 HUMAN RESOURCES

The health workforce plays a central and critical role in improving access to quality health care for the population. They are the engines of the health system and a country's ability to meet its health goals are subject to health worker's knowledge, skills and motivation level. Health system tends to underperform because of lack of human resources, limited production capacity, demographic imbalances and migration of health workers outside the country.⁷ In Nepal, the distribution of health workforce is very uneven and inadequate throughout the country. An assessment done on health workforce in 2017 reports that the country has 0.67 doctors and nurses per 1,000 population.⁸ This is significantly lower than WHO recommendation of 2.3 doctors, nurses and midwives per 1,000 population.⁹

A low level of motivation among health workers was identified in the health sector which now has improved due to adjustment and transfer of health workers to their own place after the federal structure was established. In terms of policies, a strategic plan for human resources for health (2003-2017) was developed to identify the kinds

of health care services and staff required to meet the changing health and health care needs of the population and identify short term policy actions for MoHP.

Recognising the importance of women's participation in promoting health of the people, GoN initiated the FCHV Programme in FY 2045/46 (1988/1989). The goal of FCHV programme is to support the national goal on health through community involvement in public health activities, which includes imparting knowledge and skills for empowerment of women, increasing awareness on health related issues and involvement of local institutions in promoting health care. With federalisation, mobilisation and management of FCHVs have been handed over to the *Palikas*.

RESULTS OF HUMAN RESOURCES

The strengths and weaknesses for human resource was captured based on the primary data collection that included Direct Observation, Key Informant Interview and Focus Group Discussion administered to different key stakeholders (service seeker and provider both).

Table: Strengths and weaknesses of Human Resources building block in Pratappur

Strength	Weakness
<ul style="list-style-type: none"> ▪ There is presence of skilled and competent health workers in all the health facilities. ▪ The health staffs are motivated and satisfied with their works. ▪ The HWs get transportation and per diem during trainings, workshops, supervision and monitoring visits, which are motivating to them. 	<ul style="list-style-type: none"> ▪ There is unavailability of additional staff in all health facilities during the peak times. ▪ All sanctioned positions of health workers are not fulfilled in 57% of the health facilities. ▪ There is unmanaged workload between the health staffs; some are overloaded compared to others. ▪ Job descriptions of health workers are available however; not in practical use (43% of the health facilities mentioned this.) ▪ There is no system of assessing performance of human resources allowing progress in salaries and benefits. ▪ There is no defined scheduled training and conducted on ad hoc / need basis. There is no proper training plan in the <i>Palika</i>. ▪ There is no regular technical monitoring, supervision and feedback to the health facilities and health workers by higher authorities like from Health Office, Provincial and Federal levels.

The human resource building block has been scored as 'Present but not adequate' with a score of 1.30 out of 3. The scoring shows that system and process are very limited and not sufficient. In addition, the specific

context of the *Palika*, or the seasonality are not taken into account in these processes (topics of supervisions and training, amount of public personnel, etc.), which does not always allow to respond correctly to the needs of the

7 World Health Organization, 2010: Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies.
 8 Migration of health workers from Nepal, International Labour Organisation, 2017
 9 Health Workforce requirements for Universal Health Coverage and the Sustainable Development Goals, World Health Organization, 2016

Palika. Indeed, a HR management system, which includes performance, recruitment, promotion, and transfer exist but it is partially implemented and not always well used. Health workers are recruited through the federal Public Service Commission (PSC) but provincial PSC is yet to come into function. As re-structuring of the health workers is ongoing following decentralisation, many positions are yet to be fulfilled. The *Palika* can transfer the health workers in different health facilities within the territory of the *Palika* depending on need and request from the HWs. There is performance evaluation system but is not utilised for salary progression or upgrade of the health workers.

For each type of health structure, a specific number of health staff is defined, and the adequate budget is provided by the *Palika* to cover it. However, health facility context and seasonality are not taken into account in the estimation of staff needs. At times depending on the need contractual staff are hired for instance, IMAM programme with financial support from partner agencies. The supervisions performed by the *Palika* are not always regular and of high quality. In-service training are available and provided largely by National Health Training Centre however, all activities/programmes are not covered in detail e.g. shock management; trainings not conducted during admission peaks. Pre-service trainings are mostly provided by CTEVT, a national autonomous apex body committed for the production of technical and skilful human resources, and other institutions however; all services are not covered.

The Human Resource for Health Strategy developed in 2003 was not effective because of inadequate projection, poor implementation and inadequate funding.¹⁰ Thus, a new initiative was started by developing HRH strategic plan 2011-2015. It has not been updated to the present context, but it has acted like a guideline for the HR development. A performance management system of the health personnel exists (Nepal Health Service Rules, 1999), but it is not systematically used, and only the part regarding the work completion is considered most of the time. In addition, there is not a fair and equitable management of the personnel. Moreover, a formal process for the recruitment, hiring, transfer and promotion of personnel exists, but its full utilisation is limited especially in the transfer system, so not all the personnel go through the same equitable processes. Human Resource Information System (HuRIS) is available at the federal level however, is not updated regularly and is rarely used. *Palika* level HR information management system is yet to be developed.

The number of staffs was not adequate and additional staffs were not added during the past year. Due to ongoing restructuring of health workers, not all the sanctioned positions are fulfilled, however, contractual staff were hired (not on government budget) to carry out the related activities. Public and contractual staffs are

then both present at the health facilities, and share the amount of work. The roles and responsibilities of each of them are clearly defined on the paper, however it appears that the contractual staff is working much more than the public one. Since the contractual staff does not have a permanent position, they are under more pressure and tend to work more. In case of emergency and peak season, there is also no plan to mobilise staffs adequately.

A lack of regular supervisions of the HFs has been recorded. HFs are not visited by the *Palika* nor Province for supervisions. There are few visits done by Health Office and these are not regular. Moreover, the quality of the supervisions are not always as per standards (supervision checklists and guidelines are not used). The monetary and non-monetary incentives used for supervision or others are standardised according to the published Nepal Royal Gazette notice of the Ministry of Finance.

Further, there is no training strategy at the *Palika*. Therefore, there is no accounting of the *Palika* context or needs while defining which kind of training to be carried out during the year, which can lead to important gaps in the skills of the personnel. In-service training packages should be provided to the health staff on the basis of their performance appraisal, geographical region and qualifications, however, it appears that not all the health personnel benefit from it, and it is not systematically carried out. Besides, pre-service training should be performed on a regular basis to all new health staff, including 21 day training for newly recruited staffs but, these trainings depend on the budget available and are therefore not regularly happening. There is no joint training plan that involves all the partners of the *Palika*.

The training of trainers is standardised following specific protocols/manuals/guidelines developed. But there is no integrated package of training. Most of the time, trainings are performed in Nepali as it is the common language understood by almost all the population, sometimes local or ethnic languages are also used if further clarity is required. There is no advocacy guide available for health training at the *Palika* level.

Table: Results for the Human Resources building block

Human Resources	1.30
9 Policies	1.67
10 Planning	1.50
11 Performance management	2.00
12 Training and education	0.89

¹⁰ Human Resource for Health in Nepal, Nepal Health Research Council, Kathmandu, Nepal, 2013

Supply

3.2.5 SUPPLY

According to the WHO framework for health systems¹¹, equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use are the major traits of a well-functioning health system. However, to ensure well-functioning supply system efforts must be made to ensure an effective procurement, supply and storage, and distribution systems that minimise leakage and other waste. The system should also be supported by quality assessment and support rational use of medicines, commodities and equipment, through guidelines and strategies to assure adherence, reduce resistance, and maximise patient safety and training.¹²

The Government of Nepal has been providing selected essential drugs in all district hospitals, Primary Health Care Centres (PHCC) and Health Posts (HPs) for free under the free Essential Health Care Services. The supply of medicines and drugs are organised at three levels: federal level, provincial level and local level. All the three levels procure medicines and supplies with varied threshold. At federal level, procurement of drugs required by all Provinces and the *Palikas* are done e.g. vaccines, medicine related to mental health etc. All the

essential medicines/drugs required for the continuation of basic health services need to be purchased by the Province and the *Palika*. Likewise, at the local level, *Palika* can procure immediate supplies of medicine and drugs for instance, during any disaster as well as other regular supplies. As required, health facilities send request to the *Palika* and from the *Palika* request is sent to Health Office. Following this, Health Office coordinates with the Province for the supply management.

A web based Logistics Management Information System (LMIS) has been implemented and is used to guide logistics activities by monitoring and managing the stocks and supplies. The Management Division of Department of Health Services monitor the flow of commodities at the federal level, Provincial Health Logistic Management Centre at the Province level and the *Palika* at the local level. For any procurement, a set of guidelines is available in order to facilitate the procurement process.

RESULTS OF SUPPLY

The strengths and weaknesses for supply was captured based on the primary data collection that included Direct Observation, Key Informant Interview and Focus Group Discussion administered to different key stakeholders (service seeker and provider both).

Table: Strengths and weaknesses of Supply building block in Pratappur

Strength	Weakness
<ul style="list-style-type: none"> ▪ There is availability of essential equipment e.g. thermometer, Blood pressure meter, Stethoscope etc. in the health facilities. ▪ There is possibility to order and obtain additional equipment quickly in case of shocks/emergency. ▪ There is availability of medicines and supplies/equipment from the <i>Palika</i> during shocks/emergency. ▪ Health facilities are utilising LMIS for logistic management. ▪ There is no procurement issues for procurements at the <i>Palika</i> level. 	<ul style="list-style-type: none"> ▪ Unavailability of handbooks/manuals for medicine and nutritional inputs stock management in all HFs (71% reported not available) ▪ There is availability of procurement plan but not in use/practice. ▪ There is no capacity to store medicines safely in health facilities (only available in 57% of the health facilities). ▪ There is difficulty to order and obtain sufficient medicines in case of stock out in normal situation. ▪ Unavailability of stock card in health facilities (store); if available not in use ▪ There is no assessing system for quality test of medicines and supplies at the <i>Palika</i> level. ▪ Unavailability of protection devices e.g. Fire extinguisher, radiology and laboratory equipment in the health facilities ▪ Insufficient essential medicines at HFs e.g. IFA tablets, Vitamin A, which are coming from the federal level; hence service users prefer to go to private clinics ▪ There is no integrated/joint transport mechanism for medicines and supplies. Transportations are done as and when needed and not economically viable.

11 *Everybody's business. Strengthening health systems to improve health outcomes. WHO's framework for action. Geneva, World Health Organization, 2007*

12 *World Health Organization, 2010: Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies.*

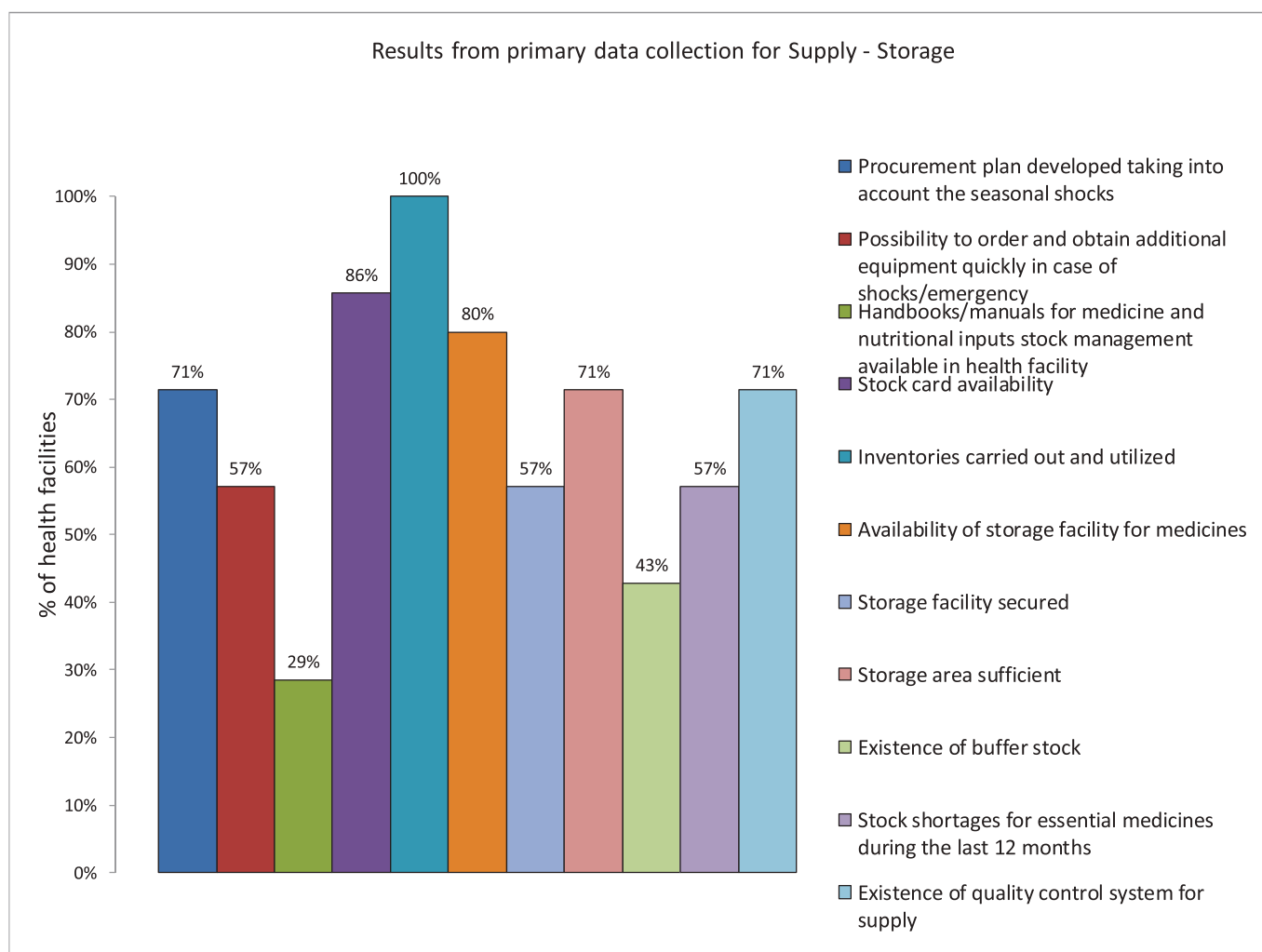
The supply building block obtained a score of 1.78 out of 3, which means that it is 'adequate.' This shows that several aspects of this building block have a good functioning such as LMIS and a well-defined supply chain. However, there are some issues in the implementation for instance, long procurement process or lack of anticipation of stock outs, which do not take into account seasonality. National Drug Policy 1995 is developed but is outdated. Drugs are procured from enlisted certified companies however, no mechanism exist to check quality and no quality check conducted on a regular basis.

Guidelines on the storage and management of drugs and other supplies exist but are partially applied (only 2 HFs out of 7). For example, the storage area for the supplies is insufficient (out of 7 health facilities, there are 2 HFs without sufficient storage area), the standards required for storage of quality are not always enforced. In the health facilities, only 57% have secured and safe

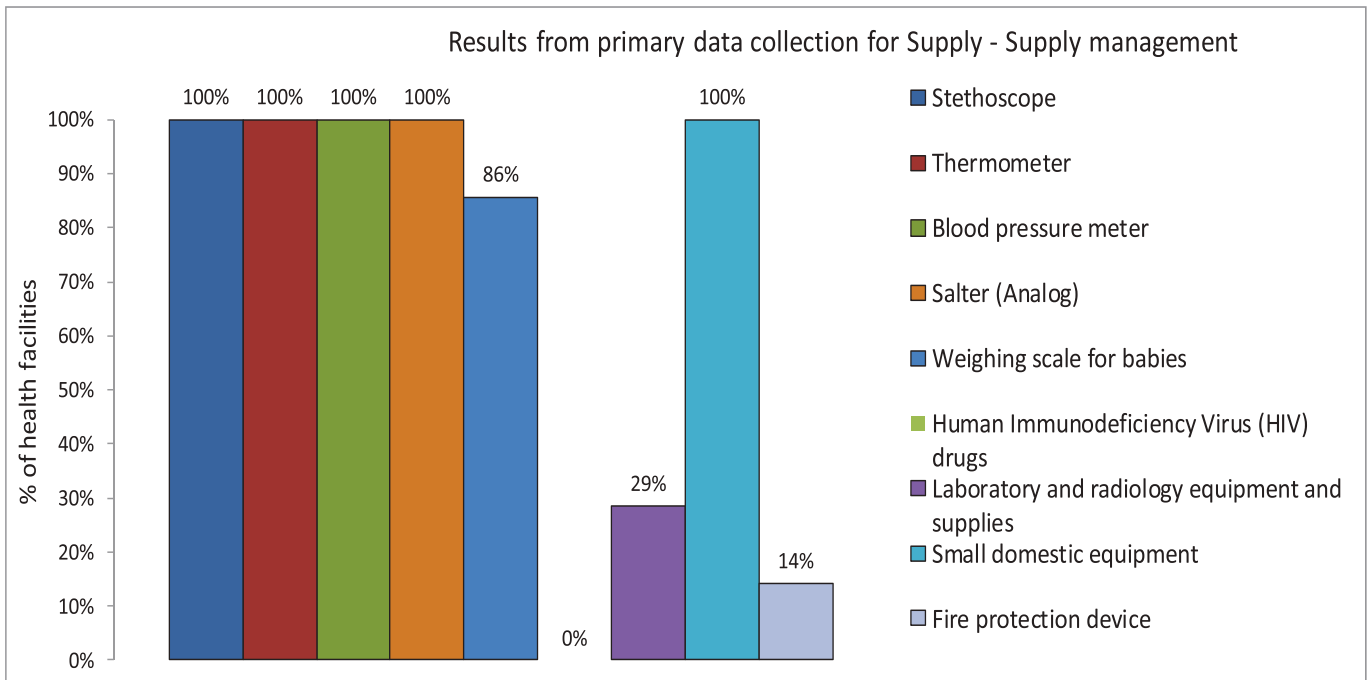
storage area i.e. there is leakage and rodents and insects in the store. There is no buffer stock available in all the health facilities (only 43% have buffer stock) and no stock management is done at the *Palika* level, hence Health Office is acting as a warehouse.

Table: Results for the Supply building block

Supply		1.78
13	Pharmaceutical policies, laws and regulations	2.00
14	Effective implementation of supply	1.67
15	Joint supply management	1.67



Graph: Summary of primary result for the supply-storage



Graph: Summary of primary result for the supply-management

There is a system of filling request form and delivery note for supplies. There has been challenges in transportation of supplies especially budgetary issue. There is availability of stock card but not maintained at the health facilities and supplies are requested on need basis with no proper scheduled supply. Hence, shortage of essential medicines

like IFA, Vitamin A, and Amoxicillin were experienced in the health facilities (57%) in the last twelve months. During any shock, the *Palika* has the ability to procure drugs but with limited threshold and should request the province for larger supplies in support with the Health Office.

Service Delivery

3.2.6 SERVICE DELIVERY

Service delivery is a vital input to improve the health of the population. Hence, one of the prime responsibilities of the health system is to ensure availability and accessibility of services, which meets minimum quality standard. The health services offered differ from one country to another but well-functioning health system should display the characteristics of Comprehensiveness, Accessibility, Coverage, Continuity, Quality, Person-centeredness, and Accountability and efficiency.¹³

The Government of Nepal first published 'Essential Health Care Services (EHCS)' package in 1999, as part of Second Long Term Health Plan. The Government's Health Sector Strategy (2004) acknowledged that the EHCS package was not affordable for the government with the available resources. The 2004 Health Sector Strategy proposed to focus on delivering four main areas of essential care across the country: safe motherhood and family planning, child health, control of communicable diseases and strengthened outpatient care, which the Nepal Health Sector Programme (NHSP) Implementation Plan 2004-2009 sought to do. The subsequent NHSP Implementation Plan 2010-2015 updated and expanded the EHCS to include new services under the reproductive health and child health areas, and new programmes on mental health, oral health, environmental health and community based nutrition care and support programme. In addition, the update includes non-communicable disease control component to address changes in epidemiological profile of the population and diseases. Furthermore, aligned with Public Health Service Act, 2075 (2018) and Public Health Service Regulation, 2077 (2020), the MoHP has prepared 'Basic Health Service Package (BHSP)' that that must be provided by the government-run health facilities to the needy for free of cost. BHSP includes 1) Immunisation services, 2) Integrated Management of Newborn and Childhood Illnesses; nutrition services; pregnancy, labour and delivery services; maternal, newborn and children health services, such as family planning, abortion and reproductive health services, 3) Services related to infectious diseases, 4) Services related to non-communicable diseases and physical distortions, 5) Mental illness services, 6) Geriatric health services, 7) General emergency services, 8) Promotional health services, and 9) Ayurveda and other traditional health services.¹⁴ However; implementation of all these services through all the health facilities of the *Palika* is still a big challenge and need huge investment besides coordination and collaboration at all tiers of the government.

Over the last decades, the Government has brought health services closer to the communities through a decentralised health system. In context of geographical accessibility, there are Health Posts, Primary Health Care Centres and hospitals established. To improve the geographic access Primary Health Care Outreach (PHC/

ORC) programme was initiated in 1994. The aim of PHC/ ORC programme was to improve access to basic health services including family planning, safe motherhood, child health, health education and counselling and first aid treatment for rural households. Based on the local needs, PHC/ORC services are conducted every month at fixed locations on specific dates and time. The services are ideally conducted at locations not more than half an hour walking distance for the population residing in that area. However, there is no adequate infrastructures with proper space and equipment is often missing. Since, such services are not available all the time and only organised in fixed dates, people are compelled to visit private clinics nearby. Following federalisation and formation of new structure with new geographical boundaries, there are many wards in the *Palika* without health facilities due to which community has been compelled to travel long distance to get health services. Hence, as per the policy of GoN, Basic Health Service Centres (BHSCs) are being established in all wards where that currently lack a HF. However, this will take time and these structures are yet to take shape in wards of *Pratappur* too, where there are no health facilities.

RESULTS OF SERVICE DELIVERY

The strengths and weaknesses for service delivery was captured based on the primary data collection that included Direct Observation, Key Informant Interview and Focus Group Discussion administered to different key stakeholders (service seeker and provider both).



13 World Health Organization, 2010: *Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies*.
14 Nepal Gazette, *Public Health Services Regulation, 2020*

Table: Strengths and weaknesses of Service delivery building block in Pratappur

Strength	Weakness
<ul style="list-style-type: none"> ▪ There is availability of essential infrastructure (100%) and equipment for service delivery (e.g. observation room (100%), waiting room (71%), electricity (100%), waste management (100%) etc. ▪ There is availability of community based health services focusing on hard-to-reach/remote areas (e.g. Outreach clinics) ▪ Regular health mothers' group meetings are held by FCHVs. 	<ul style="list-style-type: none"> ▪ Unavailability of hand-washing station (57%), separate delivery room (43%), cold chain (57%) etc. not available in all HFs ▪ Medicine stock-out is experienced in normal situation in the HFs. ▪ There is no mechanism for continuity of services during Type 1 and type 2 shocks. ▪ There are limited essential medicines available at HFs hence, service users prefer to go to private clinics. ▪ Insufficient medicines (other than enlisted in essential list) ▪ No easy access of health services to the general population e.g. lack of good transportation ▪ There is no mechanism to check the quality of services and receive feedback and complain from the community. ▪ Usually, there is no Follow-Up of referred patients. ▪ There is not good coordination between HFs and traditional healers.

Service delivery obtained a score of 1.41 out of 3 which means 'present but not adequate.' Most importantly, community participation in service delivery scored not adequate at all. There are only 3 birthing centres available in the *Palika* (*Jaganathpur* PHCC, *Pratappur* HP and *Thulo Khairtwa* HP). In these health facilities with birthing facility, on call service is only available instead of provision of 24 hours service. There are also limited Outpatient Therapeutic Care Centres (OTCCs) in the *Palika* to provide treatment to acutely undernourished children. Also all family planning methods are not available in all HFs due to limited HR and commodities.

A referral system between the different levels of the health care system exists but no proper follow up is done after referral. There is no provision of financial and/or logistic support provided to patients referred. Also, there is no referral strategy to refer patient from health facilities to higher level as and when required. Referral slip is rarely filled, when referral is done to other health facilities. Few villages in the *Palika* for instance, *Kathahawa* and *Phadki Marchawa* located in *Guthi Parsauni* is very far away, hence for services like delivery, people need to come to *Pratappur*, which is more than 7 km. Communities have access to services during opening hours in health facilities. National Strategy to reach the unreached people 2016 has been developed however not in full implementation. There is no strategy available at the *Palika* level to identify hard to reach population and services targeted for them. The geographic access is very challenging which might also lead to insufficient utilisation of services.

Table: Results for the Service delivery building block

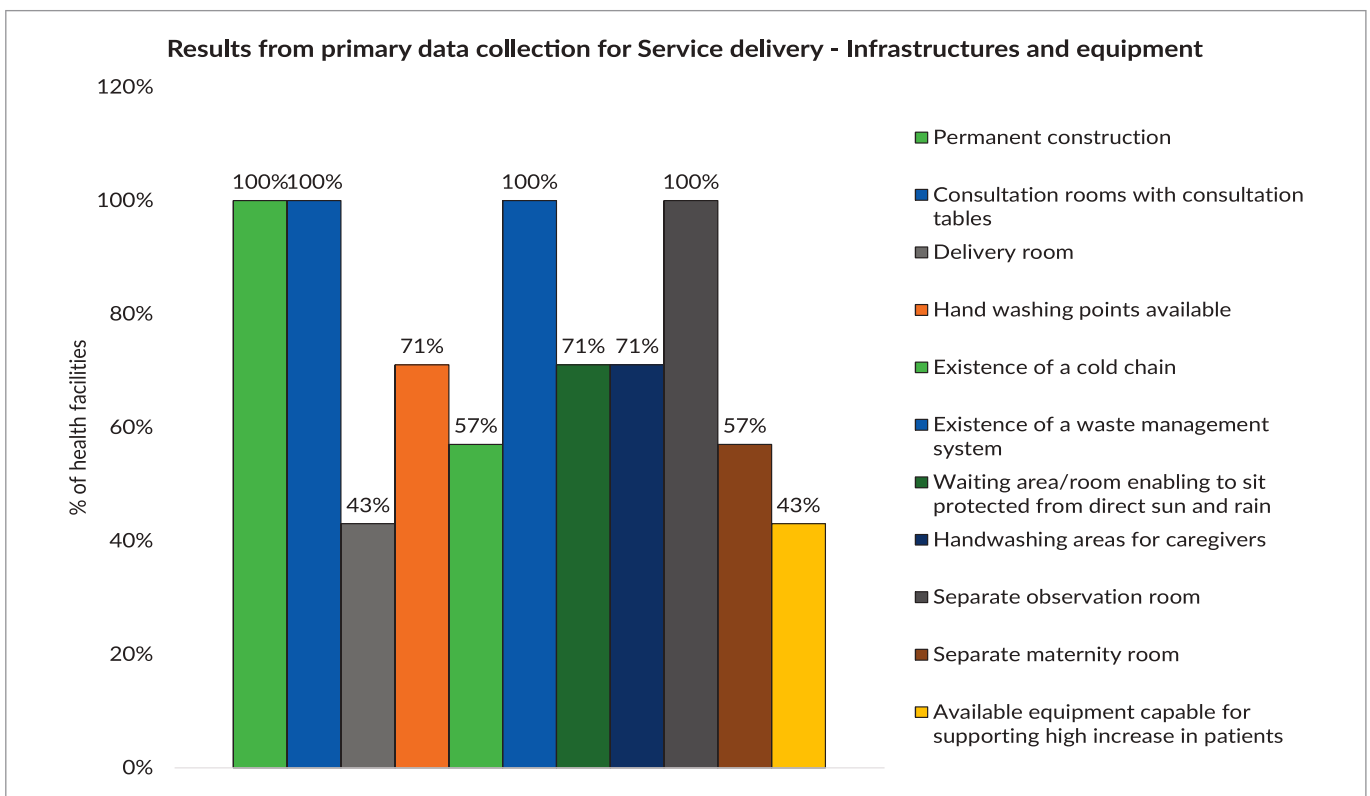
Service delivery		1.41
16	Availability and continuity of care	1.50
17	Coverage and access to RMNCH services	1.00
18	Utilisation	1.80
19	Quality assurance	1.67
20	Community participation in service delivery	0.67

Basic health care package is free in government entities however, all services are not available. All services mentioned under BHSP are not available in all health facilities of the *Palika*, which compels people to seek private health facilities. Private health clinics are expensive and people do not do insurance to cover the cost. There is no procedure adopted to ensure the access to continuity of care during shock.

There is very less utilisation of services in case of pre-natal care and attended skilled deliveries. In average only 6 women completed 4 ANC's in last six months in 6 HPs. The reason for not completing recommended 4 ANC visits was because of cross border, lack of family

support and limited transportation facility available. As per the protocol, oxytocin should be provided to women immediately after childbirth, which is available in facilities with birthing service. Basic infrastructures are present in all health facilities but maternity room, cold chain, handwashing stations etc. are available in limited health facilities. Skilled health workers are present to deliver health services and people do not have to wait long for receiving services. Triage was not established in any of the health facilities in the *Palika*, which indicates that the health facilities are not implementing standard operating procedure of screening and ill prepared for any disease outbreak e.g. COVID-19. There is a provision of monthly health mothers' group meeting conducted by FCHVs but the feedback from the community is not channelized well to take corrective action. Hence, there is no any feedback and complaint mechanism set in the community to give

feedback on the services. Private clinics are mostly the preferred choice by the public but traditional healers do not have much influence in the community. There is no any linkage between health facilities, private clinics and traditional healers. There is no existence of a mechanism to ensure engagement of civil society and communities in RMNCH service delivery. There is no consultative meeting done with the civil societies and communities for delivering quality services through the available health structure in the *Palika*. So, it can be concluded from the findings that there is limited service available and in fixed scheduled time in health facilities and people are forced to go to private clinics. There is no system in place to gather feedback and complaint from the community and hence take action for the improvement of quality of services provided.



Graph: Summary of results of primary data for Service delivery

Health Information System

3.2.7 HEALTH INFORMATION SYSTEM

Sound and reliable information is the foundation of decision-making across all health system building blocks. It is essential for health system policy development and implementation, governance and regulation, health research, human resources development, health education and training, service delivery and financing.¹⁵

The Health Information System (HIS) has four key functions: 1) data generation, 2) compilation, 3) analysis and synthesis and 4) communication and use. The HIS collects data from health and other relevant sectors, analyses the data and ensures their overall quality, relevance and timeliness and converts the data into information for health related decision making.¹⁶

In the context of Nepal, Health Management Information System (HMIS) is available at all levels of the health system. It includes mechanism of data collection, compilation, processing, dissemination, analysis and interpretation. The main objectives of HMIS are as follows:

- Monitor the achievement, coverage, continuity and quality of health services
- Monitor and evaluate health programmes
- Help in the development of appropriate health policies guidelines
- Provide access of data/information to the MoHP

Every month, HFs report more than 200 indicators via District Health Information Software (DHIS)-2. HFs must enter monthly service statistics in the national HMIS database by the 15th day of the following month. DHIS-2 is a modular web based software package for collection, validation, analysis and presentation of aggregate statistical data tailored to integrated health information management activities. For health facilities where DHIS-2 is not in practice, paper based reporting is done to the *Palika* and from the *Palika*, reports are entered in to the DHIS-2.

After the primary data collection, it was found that an annual report is prepared at the *Palika* level but no feedback mechanism exists for corrective actions. HFs' data are analysed for review meetings e.g. annual review however, no monthly performance meetings are conducted for the utilisation of health services.

Table: Number of HMIS indicators

Programme	Number of indicators
Safe Motherhood	36
Family Planning	2
Female Community Health Volunteers	10
Primary Health Care Outreach Services	4
Immunisation	28
Integrated Management of Childhood Illness	31
Nutrition	25
HIV/AIDS	24
Tuberculosis	33
Epidemiology and Disease Control Division	21
Leprosy	12
Curative Services	26
Health Facilities	28
Total Indicators	280

In addition to HMIS, there are other systems available that can complement HMIS i.e. disease surveillance system. It is called Early Warning and Response System (EWARS), which is a hospital-based sentinel surveillance system where the sentinel sites (hospitals) send weekly reports (including zero reports) on six epidemic-prone, vector-borne, water- and food-borne diseases in order to detect outbreaks. EWARS started in 1997 with eight sentinel sites and expanded to 24 sites in 1998, 26 sites in 2002, 28 sites in 2003, 40 sites in 2008, 82 sites in 2016 and 118 sites in 2020. EWARS sentinel sites are now reporting in the DHIS-2 platform, which has contributed to building better linkages with the HMIS. The weekly reporting EWARS has now been upgraded to report Severe Acute Respiratory Infection (SARI) cases on a daily basis; this facilitates monitoring of SARI cases. The Department of Drug Administration develops

15 World Health Organization, 2010: *Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies.*

16 World Health Organization, 2008: *Health Metrics Network. Framework and standards for country health information systems.*

and disseminates information on proper use of drugs, drug standard and efficacy. In 2007, Health Sector and Information Strategy (HSIS) was developed for a well-organised, comprehensive, standard and accessible national health sector information system, in order to provide a tool for evidence based decision making at all levels. Furthermore, in alignment with the Nepal Health Sector Strategy (2015-2020) and the spirit of the 15th Periodic Plan, the Integrated Health Information Management Section (IHIMS) under the Management Division has initiated integration of Routine Health Information Systems (RHISs), such as HMIS, LMIS and HHS. The section has prepared a National IHIMS Road Map (2020–2030) for the integration of different RHISs. The proposed e-Health architecture framework and the

road map will further strengthen planning, coordination and implementation of the proposed architecture blueprint among all stakeholders, particularly government and implementing partners at all levels.¹⁷

RESULTS OF HEALTH INFORMATION SYSTEM

The strengths and weaknesses for HIS was captured based on the primary data collection that included Direct Observation, Key Informant Interview and Focus Group Discussion administered to different key stakeholders (service seeker and provider both).

Table: Strengths and weaknesses of HIS building block in Pratappur

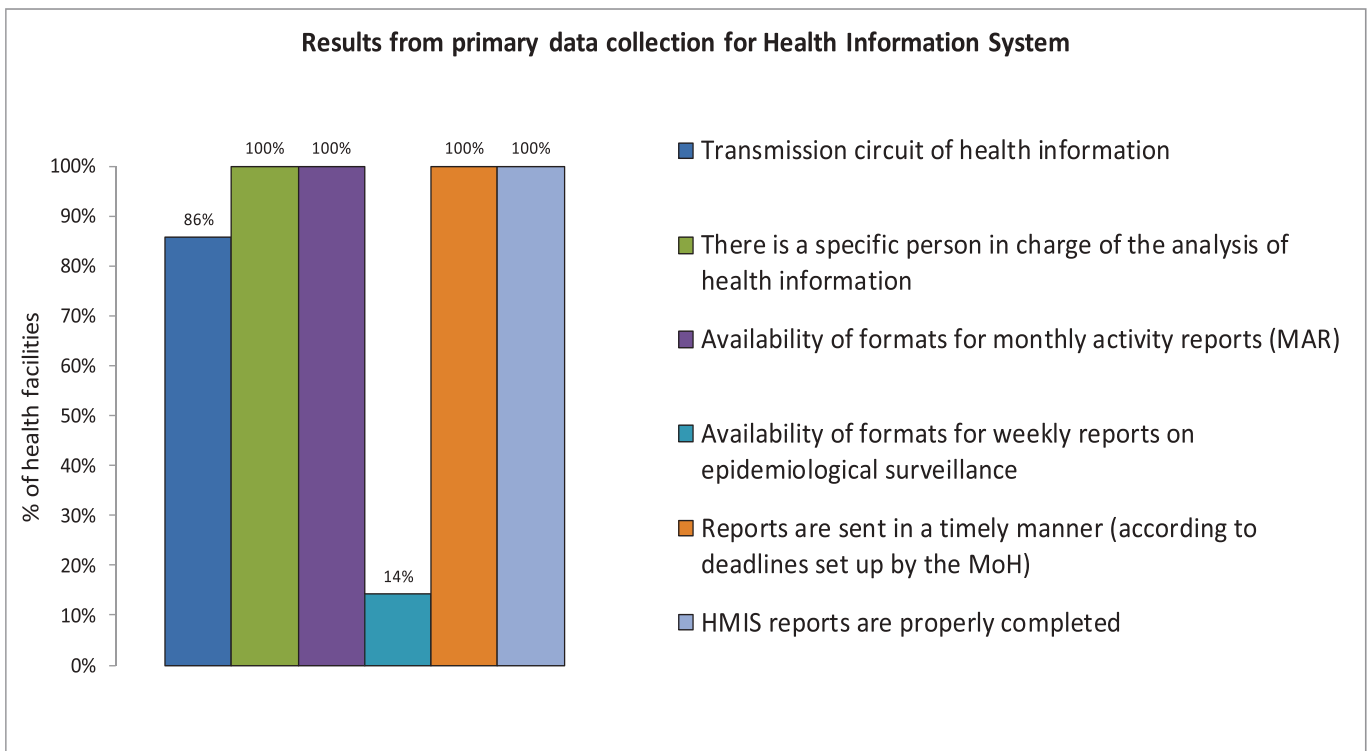
Strength	Weakness
<ul style="list-style-type: none"> ▪ There is availability of forms and formats for monthly activity reports through HMIS. ▪ HMIS reports are sent in a timely manner (according to deadlines set up by MoHP). ▪ There is specific person in charge of the analysis of health information at the health facility level and the <i>Palika</i> level. ▪ Reports are sent electronically utilising DHIS-2 through the <i>Palika</i>. ▪ Annual report is prepared at the <i>Palika</i> level. ▪ There is good transmission circuit of health information in the <i>Palika</i>. ▪ Annual public hearing is conducted by the <i>Palika</i>. 	<ul style="list-style-type: none"> ▪ Unavailability of forms and formats for weekly reports on epidemiological surveillance at the health facility level ▪ There is no analysis of HMIS reports and no feedback done. ▪ There is no system to assess quality of the HMIS reports sent. ▪ HMIS reports are not filled completely. ▪ HMIS service registers are not filled completely. ▪ Unavailability of reports to general public

The Health Information System was scored as ‘present but not adequate.’ This reflects that systems are in place for the data collection, monitoring and reporting but not implemented properly. Indeed, no proper analysis and utilisation of the data are performed to improve the programmes, assess the HFs’ performance or develop activities to better answer the specific needs of the population.

A national guide on health data collection exists but is not always correctly applied, for instance the services registers are incomplete, and the recording is not properly performed. Based on the data collected, it has been observed that HFs were sending reports timely, but it was mentioned that reports were not filled completely and the quality of the data was not satisfying. Moreover, the data are not analysed and used at the *Palika* level, only once a year the *Palika* analyses it for the yearly report, through aggregated analysis, no specific analysis per HF is done and no critical investigations are carried out. Therefore no corrective actions are developed for its proper utilisation.

Table: Results for the HIS building block

Health Information System		1.37
21	Integration of RMNCH services in Health Information System	1.71
22	Monitoring and Evaluation	0.33



Graph: Summary of results of primary data for HIS

A strong channel for the transmission of health information from grassroots level up to the federal level exists and is used by all levels. It allows reports to be sent as per the deadline set to the health facilities. However, HMIS trainings are rarely organised for the health workers. Newly recruited are trained but there is no refresher training organised, which lead to a poor management of the HMIS. The performance of the

health facilities are rarely assessed by the *Palika*, and no mechanism is in place to address it. There is no joint assessment tool designed and used to monitor different programmes. There is no Early Warning System (EWARS) and an epidemiological surveillance system in place however, RRT provides response when required. There is also no weekly reporting formats available and hence rarely implemented.

Overview of the result from the six building blocks

3.2.8 OVERVIEW OF THE RESULT FROM THE SIX BUILDING BLOCKS

All the building block except financing and supply, scored 'present but not adequate.' The two building blocks (financing and supply) got 'adequate' scoring.

When it comes to shock, governance, financing, supply and HIS have been categorised as 'highly adequate', whereas service delivery has been scored as 'not adequate at all' and HR got 'present but not adequate' scoring.

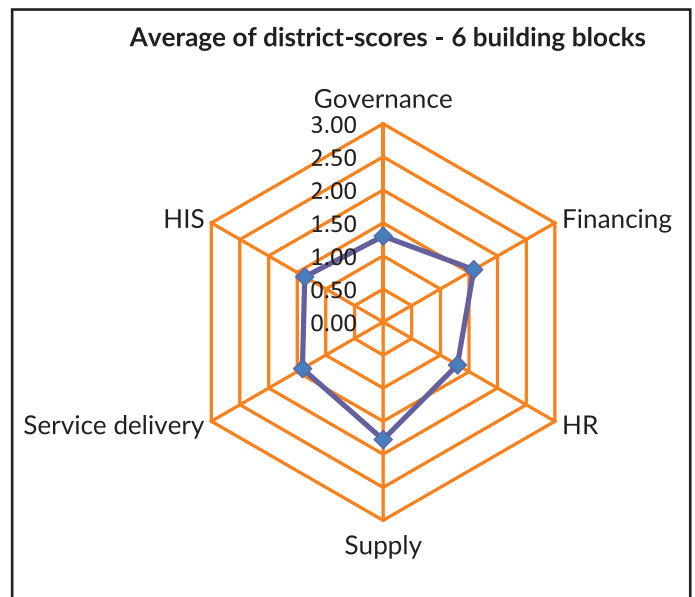


Table: Indicator results for each building block

Average scores for building blocks					
Governance	Financing	HR	Supply	Service delivery	HIS
1.30	1.58	1.30	1.78	1.41	1.37

Table: Indicator results for shock indicators of each building block

Average scores for shock indicators					
Governance	Financing	HR	Supply	Service delivery	HIS
2.00	2.00	1.00	1.83	0.67	1.53

Service delivery for shock indicators was scored as "Not adequate at all", which shows that while the minimum requirements of a health system are present in the *Palika*, however; there is difficulty in the health system to function well especially in service delivery mainly during emergencies. This was also evident during the time of COVID-19, when service delivery through the health facilities was affected. These global results suggest that the health system of the *Palika* already has a structure

in place for each of the building block except for service delivery during shock, but the functioning and operational implementation of it is the challenge.

During the diagnosis phase, COVID-19 outbreak resulted in disruption of the exercise for few months. Since, COVID-19 also has an impact in the health system building blocks, both positive and negative impact of COVID-19 in the six building blocks were also collected.

Building blocks	Positive	Negative
Governance	<ul style="list-style-type: none"> • <i>Palika</i> timely managed necessary quarantine and isolation centres. • There was maximum mobilisation of skilled human resource with high motivation by the <i>Palika</i>. • Corona response committee has been formed in every ward with dedication of responsibility. • Dissemination of public awareness messages on COVID-19 at community level is ongoing. • Health facilities tried to provide favourable atmosphere for service seeker and provider following all measures of COVID-19. • COVID-19 supported to realise coordination capacity of different stakeholders. 	<ul style="list-style-type: none"> • It was difficult to take timely decisions because COVID-19 is novel. • It was not feasible to conduct regular meetings, drafting of policies and planning and other related activities. • There is no progress as per the target set in health. • It was difficult to fully implement rules and regulations amid COVID-19
Financing	<ul style="list-style-type: none"> • There is establishment of different emergency fund amid COVID-19. • Health has been prioritised in budget allocation. • It also provided an opportunity to explore external sources and mobilisation. • There is provision of health insurance for COVID-19. 	<ul style="list-style-type: none"> • It was difficult to conduct other health related programmes, which also impacted financial progress. • There is limited investment in health due to decrease in income of <i>Palika</i> amid COVID-19. • COVID-19 increased financial burden of the <i>Palika</i>.
Human resource	<ul style="list-style-type: none"> • COVID-19 increased health related awareness among the communities i.e. physical distancing, WASH etc. • The <i>Palika</i> appointed 2 contractual staffs for the laboratory services. • The government has made provision of “risk allowance” during COVID-19. • FCHVs were mobilised with high motivation. 	<ul style="list-style-type: none"> • Health workers were also infected due to which it was difficult to deliver services. • There is increased risk due to COVID-19 for service provider as well as service seeker. • Health workers who live in rents have difficulty to convince their owner to work due to fear of COVID-19 transmission. • Untimely distribution of risk allowance to health workers • Increase in workload of health workers as they need to provide both regular and COVID-19 related services. • Lack of training to HWs on COVID-19 as it was new to all.
Supply	<ul style="list-style-type: none"> • There is gradual increase in supply of essential medicines, which was affected due to COVID-19. • Existing supplies e.g. chair, building etc. of the health facilities are utilised to the maximum during COVID-19. • The <i>Palika</i> has been able to manage isolation bed and other supplies in existing health structures 	<ul style="list-style-type: none"> • There was unavailability of supply of medicines as per demand during movement restrictions and fear of COVID-19. • There is limited COVID-19 related supplies e.g. Personal Protective Equipment. • There was insufficient resources for isolation.

Building blocks	Positive	Negative
Service delivery	<ul style="list-style-type: none"> • There is increased awareness among public about WASH, use of mask, physical distancing etc. • It seems like there is decrease in number of communicable diseases, which may be due to increased awareness on hygiene practices. • There is engagement of relevant stakeholders i.e. HWs, local elected members, civil societies in service delivery amid COVID-19. 	<ul style="list-style-type: none"> • It was difficult for service seekers/patients to take services due to unavailability of transportation, especially during movement restrictions. • It has been difficult to deliver quality services, which needed physical contact e.g. ANC/PNC check, MUAC screening etc. • It was difficult conducting regular activities i.e. monthly meetings, immunisation programme, National Vitamin A campaign, training, supply of medicines, monthly reporting etc., which is normalising now.
Health Information System	<ul style="list-style-type: none"> • COVID-19 provided an opportunity to develop and disseminate IEC/BCC materials, radio jingles related to WASH and health. • COVID-19 provided an opportunity to be familiar with new technologies e.g. ZOOM for meetings etc. 	<ul style="list-style-type: none"> • Due to circulation of myths, service seekers/patients were not coming to health facilities for essential health services • There were issues in collection of regular information/data and analysis. • It was difficult to make people understand about COVID-19 related health information.

Prioritisation



Bishnu Poudel for Action Against Hunger

Photo: Prioritisation workshop, Pratapur

3.2.9 PRIORITISATION

After the bottlenecks of the health system were identified, it was necessary to prioritise them, so that the ones with the highest priority can be addressed first. Once the various indicators were scored, the bottlenecks considered as “Not adequate at all” or “Present but not adequate” were prioritised. The criteria used for the prioritisation were defined by the participants during the workshop, and are as follows:

- Feasibility
- Availability of the funds in next 5 years
- Size of the problem
- Priority of the community
- Seriousness of problem
- *Palika's* capability
- Effectiveness
- Coherence with the *Palika's* plan

The ones with the highest priority were considered for the development of causal trees. Some bottlenecks were merged in one to create a more holistic weakness.

Table: Prioritised bottlenecks and corresponding HSS objectives

Prioritised bottlenecks	HSS objectives
Lack of sufficient, equitable, need and time based Human Resource at health facilities	Equitable, sufficient, need based and timely update of human resource management in all health facilities within 2 years (FY 2079/80)
Reports generated from Health Information System (HIS) are incomplete and of poor quality and the information is not properly utilised	Proper utilisation of data available from HMIS after detailed analysis in Pratappur rural municipality by FY 2079/80
Limited essential health services of the continuum of Reproductive, Maternal, Neonatal and Child Health (RMNCH) services available from health facilities	In 3 years, starting from FY 2077/78, the essential health services of the continuum of reproductive, maternal, new-born and child health are continuously available through the various levels of the health system
Essential health services of the continuum of Reproductive, Maternal, Neonatal and Child Health (RMNCH) services are not utilised adequately by various levels of the health system	Adequate utilisation of all the essential health services of the continuum of reproductive, maternal, Newborn and child health are continuously available through the various levels of the health system during normal and emergency situations
All essential medicines are not present in all health facilities at all time	All essential medicines are available at all times in all health facilities within 2 years starting from FY 2078/79

For each prioritised bottleneck, the causal trees are described below:

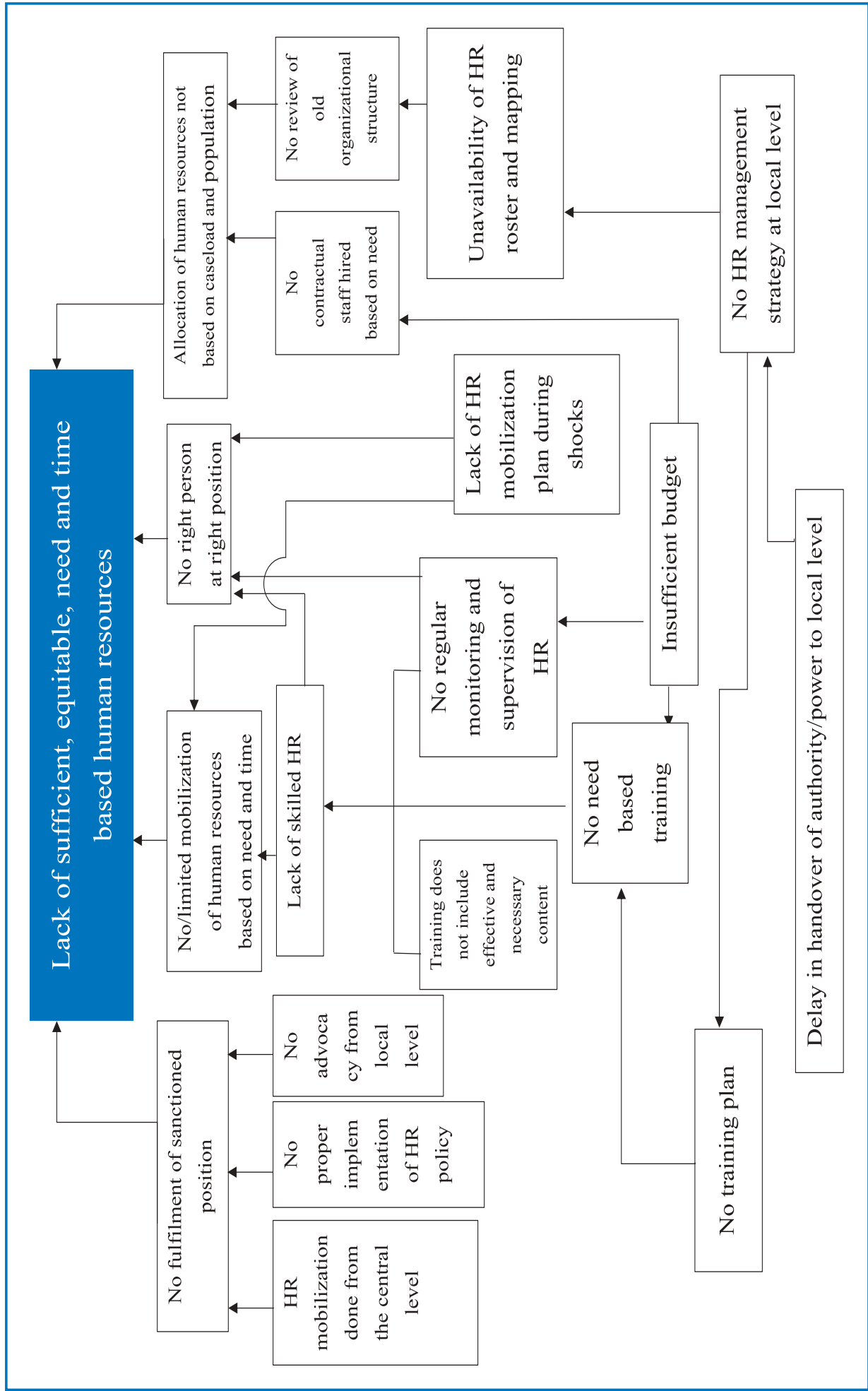


Figure: Causal tree - 1

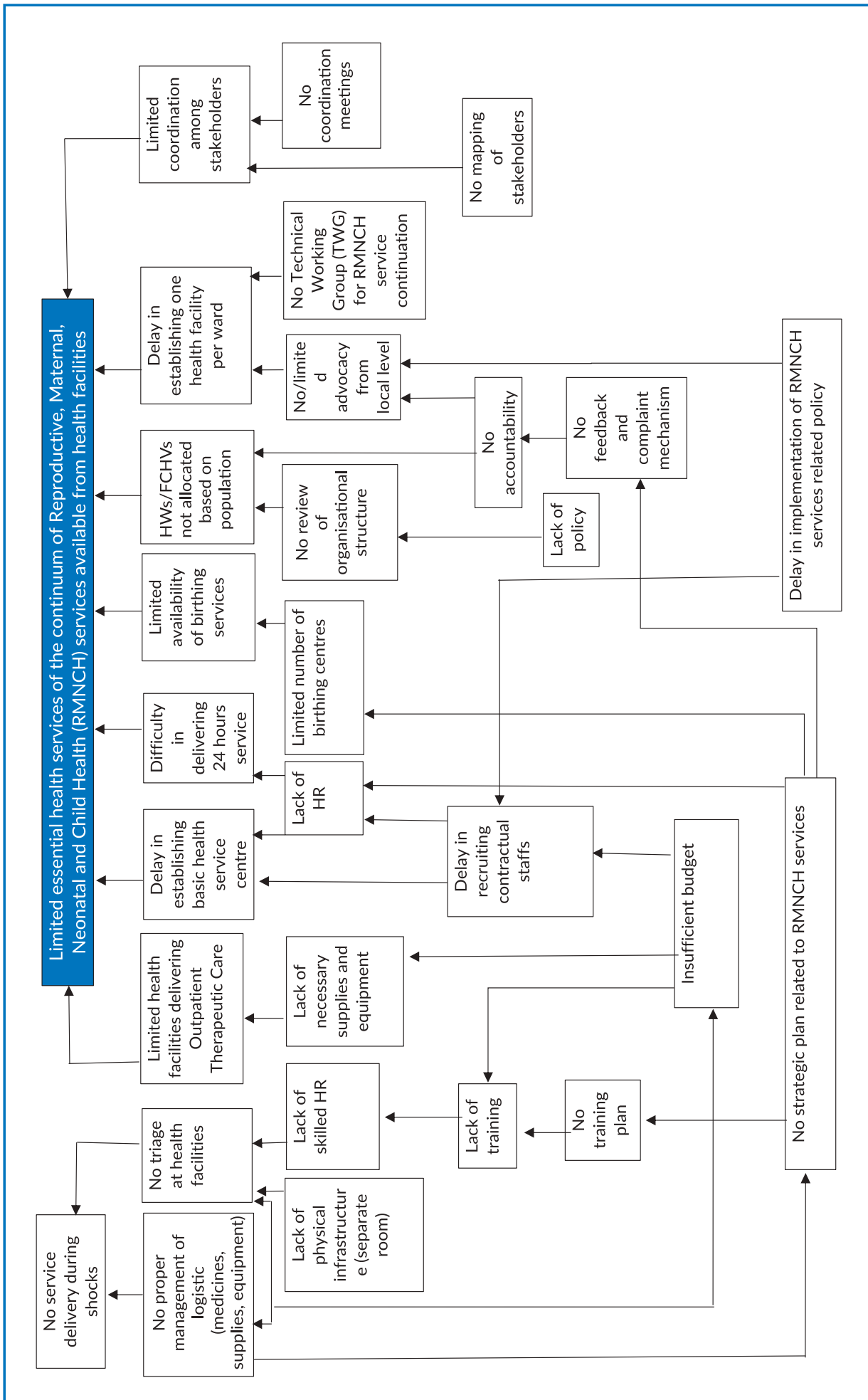


Figure: Causal tree - 3

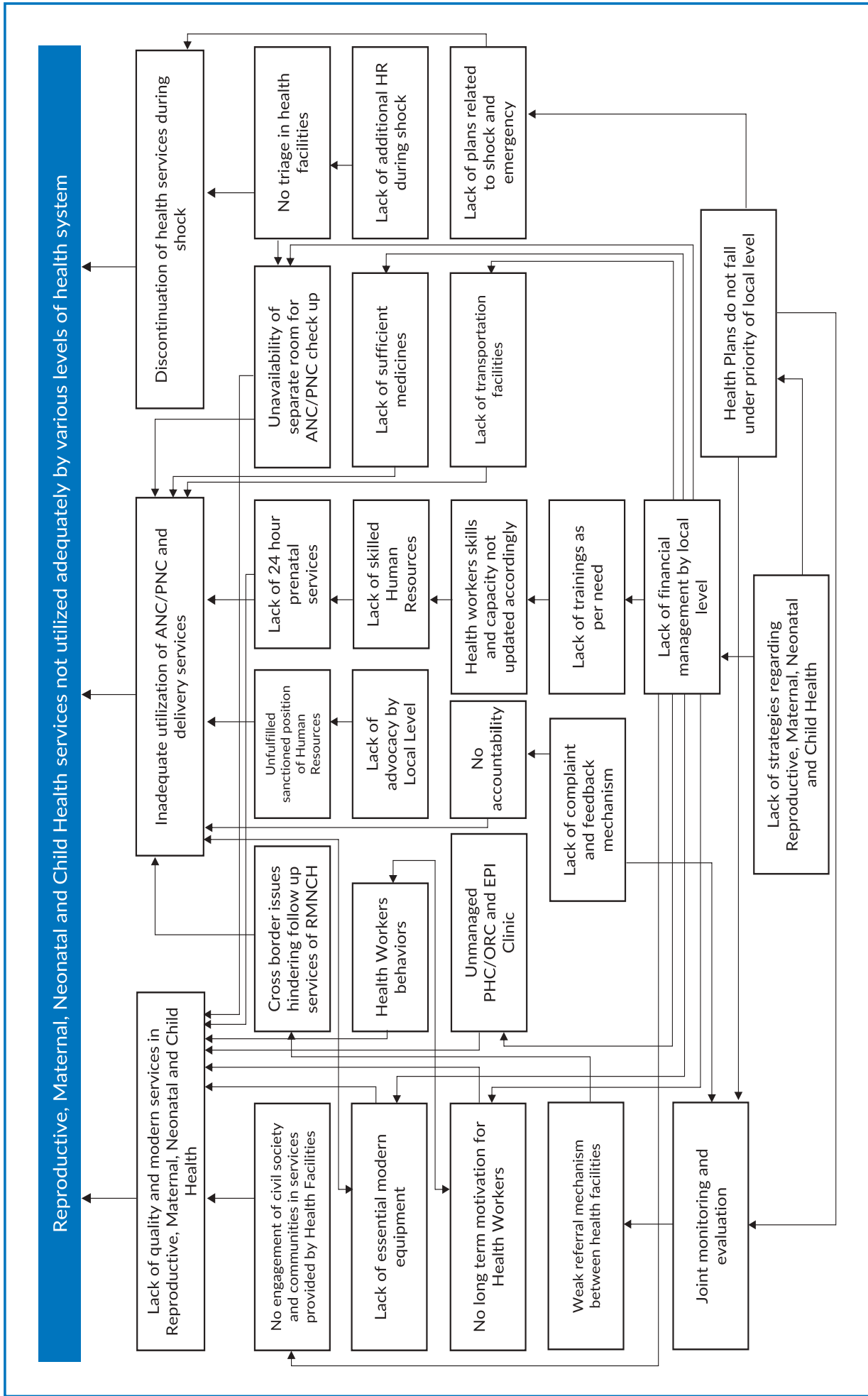


Figure: Causal tree - 4

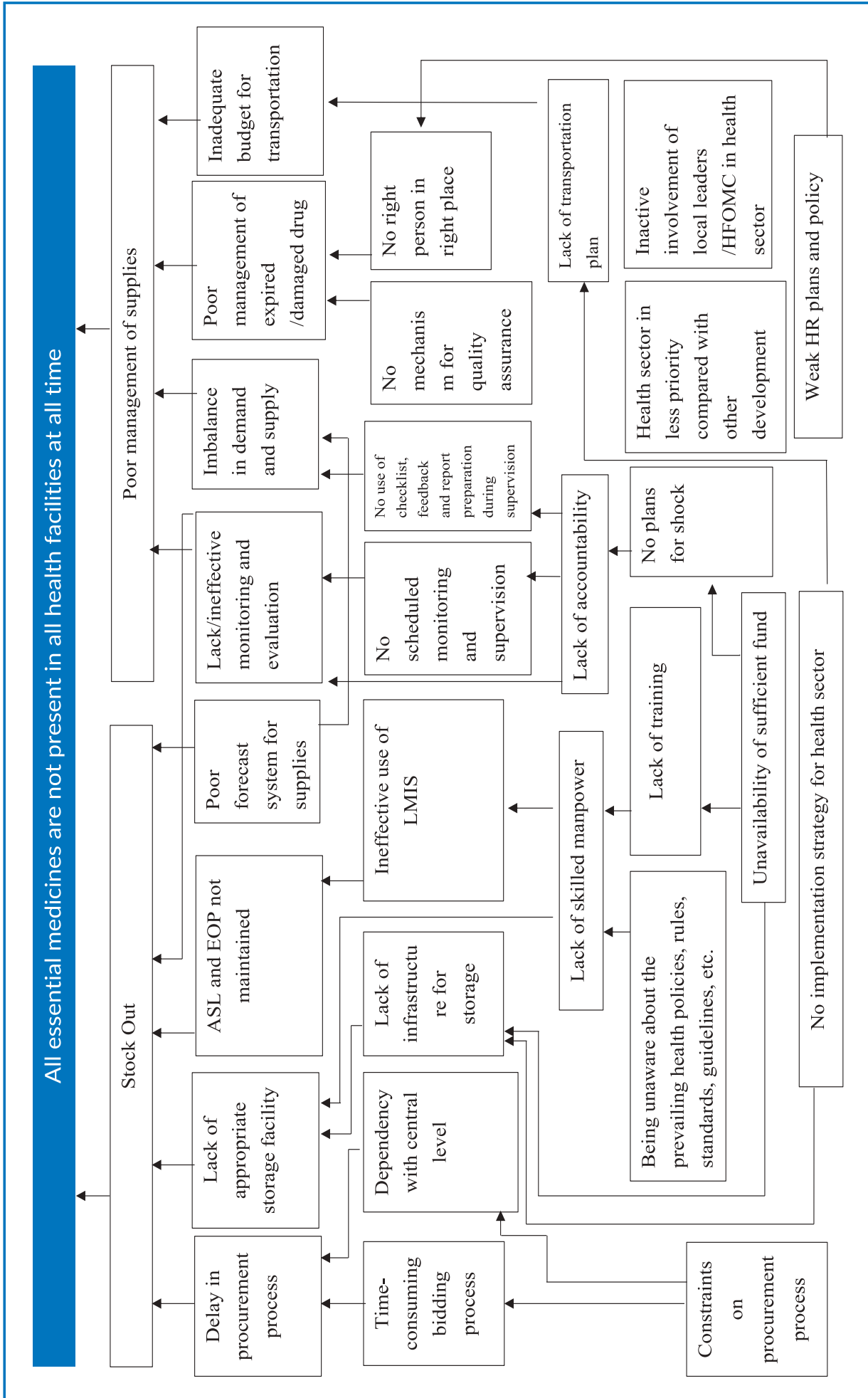


Figure: Causal tree - 5

4

PLANNING PHASE

4.1 METHODOLOGY

The previous step focused on the diagnosis on the building blocks, identifying the prioritised bottlenecks and preparing a causal trees for each prioritised bottlenecks. Following this, solution trees were developed based on the causal trees, the same structure was adopted. For each solution tree, the prioritised bottleneck was changed into a HSS SMART objective, and each cause in a solution (mirror image). Thus, HSS objectives were defined.

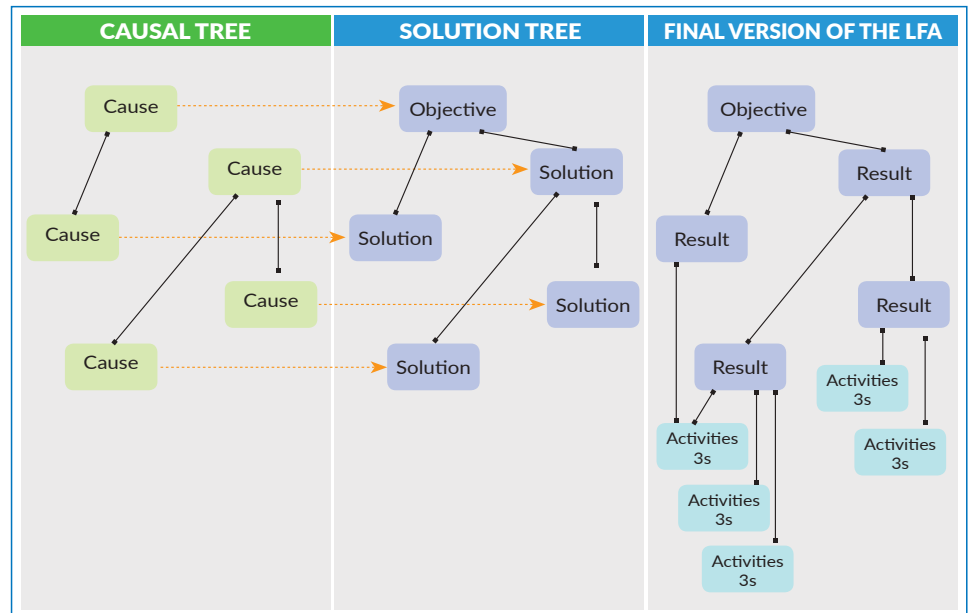


Figure: Theory of change and logical framework



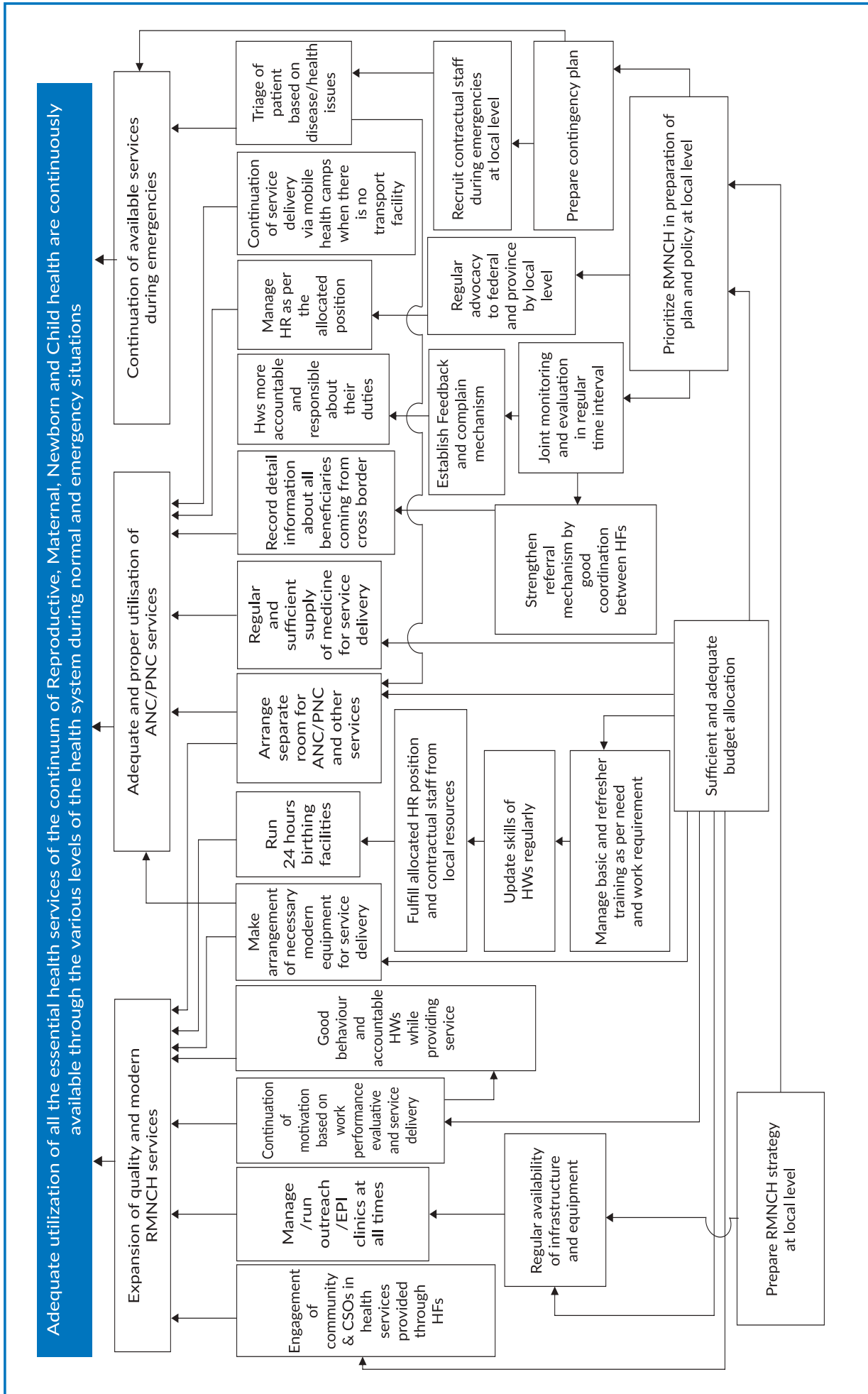


Figure: Solution tree along with HSS objective – 4

All essential medicines are available at all times in all health facilities within 2 years starting from FY 2078/79

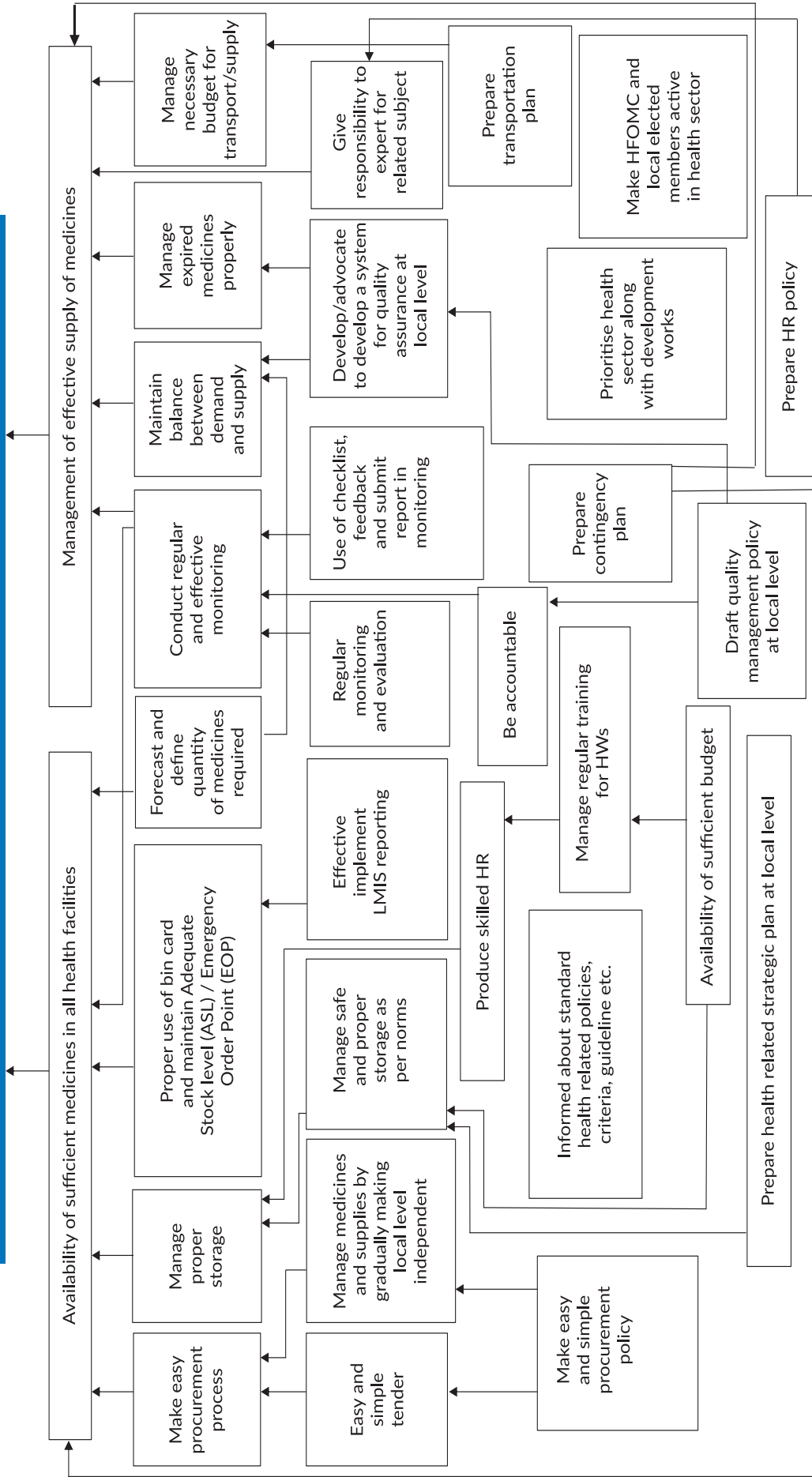


Figure: Solution tree along with HSS objective - 5

These HSS objectives were used as a basis for the development of the action plan, and several results were identified to better differentiate the 3S (strengthening, support and substitution) activities.

Strengthening: The strengthening strategy is built on the initial diagnosis presented above and focuses on the performance drivers of the system. This strategy provides benefits beyond a single disease or issue and is complementary to the support activities. Strengthening activities require a longer-term investment, and more active commitment from the health authorities, but ultimately produce results that may lead to the end of support and make the system stronger.

Support: This strategy can include any activity that improves the system's functionality primarily by increasing inputs. Support is most of the time focused on one specific issue. It offers a short term response on pre-identified key elements of the 6 building blocks. It should not be sustained, since it aims at meeting the immediate needs of the facility. It is based on the health system's initial capacity to manage a basic package, and addresses specific inputs that the local health system cannot handle. Support is supposed to decrease over time, since facility's capacity is supposed to increase along with the strengthening efforts/activities.

Substitution: This strategy goes beyond the support. In specific pre agreed situations, partners substitute the place of the health authorities, and perform most tasks by themselves. It offers short term solutions to improve the immediate access to good quality services, and is mainly focused on one specific issue. Substitution activities will mostly take place in case of important stresses/shocks undergone by the health system.

The support, strengthening and substitution strategies are complementary, and are accordingly articulated together for each phase. The idea is to arrange activities of support (short-term) together with activities of strengthening (long-term) to better respond to the needs of the *Palika*.

In order to identify and agree on all the 3S activities, a workshop was organised where Steering committee (SC) members along with representatives from all health facilities, different I/NGOs and stakeholders, HFOMC members, ward chairs within the *Palika* participated (Detailed participant list in Annex). In the workshop, a Multi-Year Costed HSS Action Plan was developed for the *Palika*, which included strengthening, support and substitution activities, for different phases i.e. normal, alert, serious and emergency for all the HSS objectives.

HSS Objective 1: Equitable, sufficient, need based and timely update of human resource management in all health facilities within 2 years (FY 2079/80)																		
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase	Budget (in NPR)	Responsible	Supporting agencies	Remarks				
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3						Normal	Alert	Serious	Emergency
Result 1: Management of staffs will be done based on allocated position																		
Strengthening	Advocate at federal level for sanction of all allocated position by sending formal letter		X															
	Identify necessary number/place of staffs required until all the allocated positions' are fulfilled at local level	X																
	Manage essential contractual staffs mobilising available resources at local level		X															
Support	Advocate by local level for full implementation of HR policy	X	X															
	Manage required staffs on a timely basis in support of supporting agencies	X	X															
Substitution	Manage skilled HR from provincial, federal and supporting agencies during emergency situations																	

HSS Objective 1: Equitable, sufficient, need based and timely update of human resource management in all health facilities within 2 years (FY 2079/80)																
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase	Budget (in NPR)	Responsible	Supporting agencies	Remarks		
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3						Normal	Alert
Result 2: Human resource will be mobilised based on need and time																
Strengthening	X			X						X	X	X	200,000	Health section, Pratappur rural municipality	Health Office, supporting agencies	
	X			X						X	X	X	-	Health section, Pratappur rural municipality	Health Office, supporting agencies	
										X	X	X	-	Health section, Pratappur rural municipality	Health Office, supporting agencies	
		X								X	X	X	640,000	Health section, Pratappur rural municipality	Health Office, supporting agencies	
		X								X	X	X	100,000	Health section, Pratappur rural municipality	Health Office, supporting agencies	

HSS Objective 1: Equitable, sufficient, need based and timely update of human resource management in all health facilities within 2 years (FY 2079/80)														
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase	Budget (in NPR)	Responsible	Supporting agencies	Remarks
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3					
Strengthening	Prepare/update roster after every training			X						X		Health section, Pratappur rural municipality		
	Conduct 4 days training for HFOMC members								X		800,000	Health section, Pratappur rural municipality	Health Office, supporting agencies	
	Conduct basic in-service training to newly appointed staff in coordination with other Palikas		X			X				X	400,000	Health section, Pratappur rural municipality	Health Office, supporting agencies	
	Document and update details of all health workers of Palika	X	X		X	X				X		Health section, Pratappur rural municipality		
	Incorporate HR mobilisation during emergency situations in contingency plan									X		Health section, Pratappur rural municipality		
	Conduct 1 day workshop to prepare HR strategy/plan for health at Palika level	X								X	60,000	Health section, Pratappur rural municipality	Health Office, supporting agencies	
	Prepare HR strategy/plan for health at Palika level				X					X		Health section, Pratappur rural municipality	Health Office, supporting agencies	

HSS Objective 1: Equitable, sufficient, need based and timely update of human resource management in all health facilities within 2 years (FY 2079/80)														
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase	Budget (in NPR)	Responsible	Supporting agencies	Remarks
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3					
Support	X			X						X	400,000	Health section, Pratappur rural municipality	Health Office, supporting agencies	
	X			X						X	As per need	Health section, Pratappur rural municipality	Supporting agencies	
										X	As per need	Health section, Pratappur rural municipality		
Substitution														
Result 3: Right person will be mobilised in right place														
Strengthening	X											Pratappur rural municipality		
	X											Pratappur rural municipality		

HSS Objective 1: Equitable, sufficient, need based and timely update of human resource management in all health facilities within 2 years (FY 2079/80)														
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase	Budget (in NPR)	Responsible	Supporting agencies	Remarks
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3					
Strengthening	X										X	Health section, Pratappur rural municipality		
	X			X						X	Health section, Pratappur rural municipality			
	X			X						X	Health facility	Health section, Pratappur rural municipality		
										X	Pratappur rural municipality			
							X			X	Pratappur rural municipality			
									X	X	Pratappur rural municipality			

HSS Objective 1: Equitable, sufficient, need based and timely update of human resource management in all health facilities within 2 years (FY 2079/80)														
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase	Budget (in NPR)	Responsible	Supporting agencies	Remarks
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3					
Strengthening			X			X						Pratappur rural municipality		
	Manage provision of reward system based on grading of health facilities									X	100,000	Pratappur rural municipality		
	Form a committee to review and update as necessary the existing health workers work performance evaluation forms and working modality		X			X				X	20,000	Health section, Pratappur rural municipality		
	Submit work performance evaluation of all health workers to work performance evaluation committee at Palika level by respective health facility in-charge or responsible officer			X			X			X	-	Health facility	Health section, Pratappur rural municipality	
Provide a copy of work performance evaluation to each health workers after completion of work performance evaluation			X			X			X	-	Health facility	Health section, Pratappur rural municipality		

HSS Objective 1: Equitable, sufficient, need based and timely update of human resource management in all health facilities within 2 years (FY 2079/80)															
Support	Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase	Budget (in NPR)	Responsible	Supporting agencies	Remarks
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3					
Support	Recruit contractual staff for service delivery	X	X	X	X	X	X				X	500,000	Health section, Pratappur rural municipality	Supporting agencies	
	Manage staff for continuation of essential health related services during emergency by supporting agencies											As per need	Supporting agencies	Health section, Pratappur rural municipality	

HSS Objective 2: Proper utilisation of data available from HMIS after detailed analysis in Pratappur rural municipality by FY 2079/80															
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase	Budget (in NPR)	Responsible	Supporting agencies	Remarks	
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3						Normal
Result 1: A system of disseminating health information will be utilised															
Strengthening	Regular discussion about health and nutrition in health mothers' group meeting in presence of health workers and submit its report	X	X	X	X	X				X	X	790,000	Health facilities; Health section, Pratappur rural municipality		
	Discuss and provide information about health and nutrition in outreach clinics and EPI clinics and submit its report	X	X	X	X	X				X	X	585,600	Health facilities; Health section, Pratappur rural municipality		
	Organise public hearing of health programmes in presence of local elected members and other stakeholders and submit its report			X						X	X	100,000	Health section, Pratappur rural municipality	Health facilities	
	Manage/update citizen charter and information sheet in all health facilities	X	X	X	X	X				X	X	56,000	Health facilities; Health section, Pratappur rural municipality		

HSS Objective 2: Proper utilisation of data available from HMIS after detailed analysis in Pratappur rural municipality by FY 2079/80																	
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase	Budget (in NPR)	Responsible	Supporting agencies	Remarks			
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3						Normal	Alert	Serious
Disseminate information about all the services provided by health facilities via different communication mediums in local language for public	X	X	X	X	X	X				X	X	X	X	50,000	Health section, Pratappur rural municipality	Supporting agencies	
	X									X				10,000	Health section, Pratappur rural municipality	Supporting agencies	
	X	X	X	X	X	X				X	X	X		200,000	Health section, Pratappur rural municipality	Provincial and federal government; Health Office; supporting agencies	
	X			X						X	X			50,000	Health section, Pratappur rural municipality	Health Office, supporting agencies	
Prepare and implement joint/integrated plan for information dissemination in coordination with different supporting agencies within Palika																	
Reaching out public during yearly health and nutrition related national/international days celebration	X	X	X	X	X	X				X	X	X					
Prepare health and nutrition yearly report of Palika and make it public	X			X													
Support																	

HSS Objective 2: Proper utilisation of data available from HMIS after detailed analysis in Pratappur rural municipality by FY 2079/80															
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase	Budget (in NPR)	Responsible	Supporting agencies	Remarks	
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3						Normal
Strengthening	X										X	100,000	Health section, Pratappur rural municipality		
	X	X	X	X	X	X				X		50,000	Health section, Pratappur rural municipality		
	X			X						X		-	Health section, Pratappur rural municipality		
			X							X	X	-	Health section, Pratappur rural municipality		
										X		-	Health section, Pratappur rural municipality		
			X							X		-	Health section, Pratappur rural municipality		

HSS Objective 2: Proper utilisation of data available from HMIS after detailed analysis in Pratappur rural municipality by FY 2079/80																	
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase	Budget (in NPR)	Responsible	Supporting agencies	Remarks			
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3						Normal	Alert	Serious
Support	Provide a set of computer in health facilities without computer for data recording and report writing	X	X	X							X			500,000	Health section, Pratappur rural municipality	Supporting agencies	
	Conduct 3 days of basic HMIS training for health workers			X						X				50,000	Health section, Pratappur rural municipality	Health Office; supporting agencies	
	Conduct 2 days of HMIS refresher training for health workers									X				150,000	Health section, Pratappur rural municipality	Health Office; supporting agencies	
	Conduct 2 days of HMIS refresher training for FCHVs		X	X										150,000	Health section, Pratappur rural municipality	Health Office; supporting agencies	
Conduct 4 days of basic DHIS-2 training for health workers			X										250,000	Health section, Pratappur rural municipality	Health Office; supporting agencies		

HSS Objective 2: Proper utilisation of data available from HMIS after detailed analysis in Pratappur rural municipality by FY 2079/80																	
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase	Budget (in NPR)	Responsible	Supporting agencies	Remarks			
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3						Normal	Alert	Serious
Strengthening	Monitor data statistics during regular monitoring of health facilities	X	X	X	X	X	X	X	X	X	X	X	X	X	Health section, Pratappur rural municipality	Health Office	
	Use of monitoring checklist inclusive of data related indicators	X	X	X	X	X	X	X	X	X	X	X	X	X	Health section, Pratappur rural municipality	Health Office	
	Appoint a responsible person if incomplete and poor quality data is observed during monitoring and supervision by preparing an implementation plan and its follow up	X	X	X	X	X	X	X	X	X	X	X	X	X	Health section, Pratappur rural municipality	Health Office	
	Provide feedback mandatorily post monitoring and supervision	X	X	X	X	X	X	X	X	X	X	X	X	X	Health section, Pratappur rural municipality	Health Office	
Conduct quarterly Routine Data Quality Assurance (RDQA) in all health facilities	X	X	X	X	X	X	X	X	X	X	X	X	X	64,800	Health section, Pratappur rural municipality	Health Office	

HSS Objective 2: Proper utilisation of data available from HMIS after detailed analysis in Pratappur rural municipality by FY 2079/80																
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase	Budget (in NPR)	Responsible	Supporting agencies	Remarks		
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3						Normal	Alert
Strengthening				X						X	X	X		Health section, Pratappur rural municipality		
		X		X	X					X	X	X		Health section, Pratappur rural municipality		
		X		X	X	X				X	X	X		Health section, Pratappur rural municipality		
Support	X									X	X	X	100,000	Health section, Pratappur rural municipality	Health Office. Supporting agencies	
													As per need	Supporting agencies	Health section, Pratappur rural municipality; Health Office	
Substitution																

HSS Objective 3: In 3 years, starting from FY 2077/78, the essential health services of the continuum of Reproductive, Maternal, New-born and Child Health are continuously available through the various levels of the health system																					
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase	Budget (in NPR)	Responsible	Supporting agencies	Remarks							
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3						Normal	Alert	Serious	Emergency			
Result 1: All RMNCH services will be regularly functional during emergency situations																					
Strengthening	X											X					Form Technical Working Groups to prepare contingency plan for continuation of RMNCH services from all health facilities and <i>Palika</i> during emergency situations	Health Office; District Administration Office; District Coordination Committee; supporting agencies	Health section, Pratappur rural municipality	Health Office; District Administration Office; District Coordination Committee; supporting agencies	
	X	X										X			150,000		Conduct workshop to prepare contingency plan at health facilities and <i>Palika</i> level	Health Office; District Administration Office; District Coordination Committee; supporting agencies	Health facilities; Health section, Pratappur rural municipality	Health Office; District Administration Office; District Coordination Committee; supporting agencies	
	X	X										X			-		Draft contingency plan after incorporating suggestions/discussion from the contingency planning workshop	Health Office; District Administration Office; District Coordination Committee; supporting agencies	Health facilities; Health section, Pratappur rural municipality	Health Office; District Administration Office; District Coordination Committee; supporting agencies	

HSS Objective 3: In 3 years, starting from FY 2077/78, the essential health services of the continuum of Reproductive, Maternal, New-born and Child Health are continuously available through the various levels of the health system																
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase	Budget (in NPR)	Responsible	Supporting agencies	Remarks		
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3						Normal	Alert
Strengthening	Endorse contingency plan of all health facilities and Palika providing RMNCH services through village council meetings			X										Pratappur rural municipality		
	Conduct 2 days' workshop to prepare strategic plan on RMNCH services at the local level	X								X			120,000	Health section, Pratappur rural municipality	Health Office; District Administration Office; District Coordination Committee; supporting agencies	
	Form Technical Working Groups and Advisory Committee to prepare strategic plan on RMNCH services at the local level	X								X			-	Health section, Pratappur rural municipality		
	Prepare final draft of the strategic plan after collection of suggestions and feedback from different stakeholders		X								X		-	Health section, Pratappur rural municipality	Health Office, supporting agencies	

HSS Objective 3: In 3 years, starting from FY 2077/78, the essential health services of the continuum of Reproductive, Maternal, New-born and Child Health are continuously available through the various levels of the health system																	
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Strengthening	Endorse strategic plan on RMNCH services at the local level from village council			X								X			-	Pratappur rural municipality	
	Conduct 1 day orientation programme on presenting strategic plan to representatives of all health facilities											X			50,000	Health section, Pratappur rural municipality	
	Mobilise Rapid Response Team (RRT) from health facilities during emergency situations												X		As per need	Health section, Pratappur rural municipality	
Support	Establish emergency fund and its working modalities at Palika level														500,000	Pratappur rural municipality	Health Office, supporting agencies
	Conduct triage assessment of all health facilities to collect information on the situation and physical infrastructures	X													70,000	Health section, Pratappur rural municipality	Health Office, supporting agencies

HSS Objective 3: In 3 years, starting from FY 2077/78, the essential health services of the continuum of Reproductive, Maternal, New-born and Child Health are continuously available through the various levels of the health system														
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase	Budget (in NPR)	Responsible	Supporting agencies	Remarks
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3					
Support	Procure materials for triage implementation based on the assessment result	X								X	100,000	Health section, Pratappur rural municipality	Health Office, supporting agencies	
	Develop IEC materials for triage	X								X	30,000	Health section, Pratappur rural municipality	Health Office, supporting agencies	
	Conduct 1 day orientation on triage to all health workers of all health facilities and hospital									X	70,000	Health section, Pratappur rural municipality	Health Office, supporting agencies	
Provide incentives based on risk to human resource mobilised during emergency situations											As per need	Health section, Pratappur rural municipality	Supporting agencies	
Substitution	Provide services via supporting agencies during emergency situations										As per need	Supporting agencies	Health section, Pratappur rural municipality	

HSS Objective 3: In 3 years, starting from FY 2077/78, the essential health services of the continuum of Reproductive, Maternal, New-born and Child Health are continuously available through the various levels of the health system																		
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase	Budget (in NPR)	Responsible	Supporting agencies	Remarks				
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3						Normal	Alert	Serious	Emergency
Strengthening	X																	
										X								
Incorporate provision of providing 24 hours service from Jagannathpur Primary Health Care Centre (PHCC) while preparing RMNCH services related strategic plan at Palika																		
Allocate budget for HR mobilisation (additional 1 ANM and 1 AHW) to provide 24 hours services from Jagannathpur Primary Health Care Centre																		
Manage materials and equipment required for establishing birthing centre in Guthi Suryapura after allocation of necessary budget																		

HSS Objective 3: In 3 years, starting from FY 2077/78, the essential health services of the continuum of Reproductive, Maternal, New-born and Child Health are continuously available through the various levels of the health system																	
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase	Budget (in NPR)	Responsible	Supporting agencies	Remarks			
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3						Normal	Alert	Serious
Strengthening	Appoint necessary Skilled Birth Attendant (SBA) to provide services from Guthi Suryapura birthing centre			X									Health section, Pratappur rural municipality				
	Allocate necessary budget to establish birthing centre in Guthi Parsauni health facility									X			Health section, Pratappur rural municipality				
	Build infrastructure to establish birthing centre in Guthi Parsauni health facility												Health section, Pratappur rural municipality			Type 'B' health facility	
	Procure necessary materials and equipment to provide services from birthing centre in Guthi Parsauni health facility												18,000,000	Health section, Pratappur rural municipality			
	Procure necessary materials and equipment to provide services from birthing centre in Guthi Parsauni health facility												500,000	Health section, Pratappur rural municipality			
	Appoint necessary Skilled Birth Attendant (SBA) to provide services from Guthi Parsauni birthing centre												240,500	Health section, Pratappur rural municipality			

HSS Objective 3: In 3 years, starting from FY 2077/78, the essential health services of the continuum of Reproductive, Maternal, New-born and Child Health are continuously available through the various levels of the health system														
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase	Budget (in NPR)	Responsible	Supporting agencies	Remarks
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3					
Strengthening	X									X	200,000	Health section, Pratappur rural municipality		
	X								X	721,500	Health section, Pratappur rural municipality			
									X	200,000	Health section, Pratappur rural municipality			
									X	721,500	Health section, Pratappur rural municipality			

HSS Objective 3: In 3 years, starting from FY 2077/78, the essential health services of the continuum of Reproductive, Maternal, New-born and Child Health are continuously available through the various levels of the health system																		
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase	Budget (in NPR)	Responsible	Supporting agencies	Remarks				
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3						Normal	Alert	Serious	Emergency
Strengthening	Build infrastructure to establish birthing centre in <i>Baidhaulii</i> health facility			X													Type 'B' health facility	
	Procure necessary materials and equipment to provide services from birthing centre in <i>Baidhaulii</i> health facility			X														
	Appoint necessary Skilled Birth Attendant (SBA) to provide services from <i>Baidhaulii</i> birthing centre																	
	Manage physical infrastructure and equipment to run laboratory services in <i>Baidhaulii</i> health facility																	
	Manage contractual health workers (Lab Assistant) to run laboratory services in <i>Baidhaulii</i> health facility																	

HSS Objective 3: In 3 years, starting from FY 2077/78, the essential health services of the continuum of Reproductive, Maternal, New-born and Child Health are continuously available through the various levels of the health system															
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase	Budget (in NPR)	Responsible	Supporting agencies	Remarks	
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3						Normal
Strengthening	Establish health facility in Ward no. 1 and 8 as per the policy to establish health facility in each ward				X	X	X	X	X	X	X	3,283,560	Health section, Pratappur rural municipality	Provincial and federal government	Building in rent, land obtained in kind/ donation (No budget allocated), only salary of staffs required
	Manage suggestion box in all health facilities to develop and implement feedback and complaints mechanism	X								X		12,000	Health section, Pratappur rural municipality		
	Appoint a focal person in all health facilities for the monthly recording and management of all collected complaints and feedback via suggestion box	X									X		-	Health section, Pratappur rural municipality	

HSS Objective 3: In 3 years, starting from FY 2077/78, the essential health services of the continuum of Reproductive, Maternal, New-born and Child Health are continuously available through the various levels of the health system																		
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks	
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency					
Strengthening	X												X	X		Health section, Pratappur rural municipality		
		X			X			X					X	X		Health section, Pratappur rural municipality		
	X												X	X		Health section, Pratappur rural municipality		
Support		X													75,000	Health section, Pratappur rural municipality	Health Office; Supporting agencies	
															2,400,000	Health section, Pratappur rural municipality	Supporting agencies	

HSS Objective 4: Adequate utilisation of all the essential health services of the continuum of Reproductive, Maternal, Newborn and Child Health are continuously available through the various levels of the health system during normal and emergency situations																		
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase	Budget (in NPR)	Responsible	Supporting agencies	Remarks				
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3						Normal	Alert	Serious	Emergency
Result 1: Quality and modern RMNCH services will be initiated and expanded																		
Strengthening	X		X	X		X					X					235,800	Health section, Pratappur rural municipality	
	X	X	X	X		X					X					1,512,000	Health section, Pratappur rural municipality	
	X	X	X	X		X					X					194,400	Health section, Pratappur rural municipality	

HSS Objective 4: Adequate utilisation of all the essential health services of the continuum of Reproductive, Maternal, Newborn and Child Health are continuously available through the various levels of the health system during normal and emergency situations														
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase	Budget (in NPR)	Responsible	Supporting agencies	Remarks
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3					
Strengthening	X	X	X	X	X	X				X	X	Health section, Pratappur rural municipality		
	X	X	X	X	X	X				X		Health section, Pratappur rural municipality		
	X	X	X	X	X	X				X		Health facility		
Conduct informative session on availability of health services to youth clubs and Tole (area) Reform Committees	X	X	X	X	X	X				X	129,600	Health facility	Health section, Pratappur rural municipality	
Continue to provide financial incentives to pregnant and lactating women completing 4 ANC visits, institutional delivery and 3 PNC visits	X	X	X	X	X	X				X	6,445,000	Health section, Pratappur rural municipality	Health facility	
Continue to provide support (materials) provided to Golden 1000 days mothers and children in a well-managed way	X	X	X	X	X	X				X	5,156,000	Health section, Pratappur rural municipality	Health facility	
Form evaluation committee at Palika for conducting work performance appraisal of FCHVs	X									X	-	Health section, Pratappur rural municipality	Health facility	

HSS Objective 4: Adequate utilisation of all the essential health services of the continuum of Reproductive, Maternal, Newborn and Child Health are continuously available through the various levels of the health system during normal and emergency situations															
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase	Budget (in NPR)	Responsible	Supporting agencies	Remarks	
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3						Normal
Strengthening	X									X			Health section, Pratappur rural municipality	Health facility	
	X									X			Health section, Pratappur rural municipality	Health facility	
	X						X			X			Health section, Pratappur rural municipality		
	X									X			Health section, Pratappur rural municipality	Health Office	

HSS Objective 4: Adequate utilisation of all the essential health services of the continuum of Reproductive, Maternal, Newborn and Child Health are continuously available through the various levels of the health system during normal and emergency situations															
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase		Budget (in NPR)	Responsible	Supporting agencies	Remarks
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert				
Strengthening	X	X	X	X	X	X						150,000	Health section, Pratappur rural municipality	Health Office	All results related to monitoring and supervision
	X	X	X	X	X	X				X	X	40,000	Health section, Pratappur rural municipality		
Support	X	X	X	X	X	X				X		30,000,000	Pratappur rural municipality	Supporting agencies	
		X								X		6,000,000	Pratappur rural municipality	Supporting agencies	

HSS Objective 4: Adequate utilisation of all the essential health services of the continuum of Reproductive, Maternal, Newborn and Child Health are continuously available through the various levels of the health system during normal and emergency situations															
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase	Budget (in NPR)	Responsible	Supporting agencies	Remarks	
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3						Normal
Support	X	X	X	X	X	X				X	X	60,000	Health section, Pratappur rural municipality	Supporting agencies	
Substitution												As per need	Supporting agencies	Health section, Pratappur rural municipality	
Result 2: Use of prenatal, postnatal and delivery services will be done adequately															
Strengthening	X	X	X	X	X	X				X			Health facility	Health section, Pratappur rural municipality	
Manage and update Adequate Stock Level (ASL) and Emergency Order Point (EOP) of essential medicines and equipment required for prenatal, postnatal and delivery services															

HSS Objective 4: Adequate utilisation of all the essential health services of the continuum of Reproductive, Maternal, Newborn and Child Health are continuously available through the various levels of the health system during normal and emergency situations														
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase	Budget (in NPR)	Responsible	Supporting agencies	Remarks
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3					
Strengthening	X	X	X	X	X	X				X			Health section, Pratappur rural municipality	
	X	X	X	X	X	X				X			Health section, Pratappur rural municipality	
	X	X	X	X	X	X				X			Health section, Pratappur rural municipality	
	X	X	X	X	X	X				X	168,000		Health section, Pratappur rural municipality	
Conduct discussion around referral mechanism in each monthly and semi-annual meetings	X	X	X	X	X	X				X			Health section, Pratappur rural municipality	

HSS Objective 4: Adequate utilisation of all the essential health services of the continuum of Reproductive, Maternal, Newborn and Child Health are continuously available through the various levels of the health system during normal and emergency situations															
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase	Budget (in NPR)	Responsible	Supporting agencies	Remarks	
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3						Normal
Strengthening	X									X		48,000	Health section, Pratappur rural municipality		
	X									X		-	Health section, Pratappur rural municipality		
										X		-	Health section, Pratappur rural municipality		
	X									X		98,000	Health section, Pratappur rural municipality	Health Office; Federation of Journalists; civil society network; supporting agencies	

HSS Objective 4: Adequate utilisation of all the essential health services of the continuum of Reproductive, Maternal, Newborn and Child Health are continuously available through the various levels of the health system during normal and emergency situations																	
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Support	X		X			X							X	294,000	Health facility	Health section, Pratappur rural municipality; Health Office; supporting agencies	
Substitution																	
													X	As per need	Supporting agencies	Health section, Pratappur rural municipality	
													X	As per need	Supporting agencies	Health Office; Health section, Pratappur rural municipality	

HSS Objective 5: All essential medicines are available at all times in all health facilities within 2 years starting from FY 2078/79																		
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks	
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency					
Result 1: Supply of medicines will be sufficient in all health facilities																		
Strengthening	X		X			X					X	X	X	X	-	Health section, Pratappur rural municipality	Health Office	
	X			X							X	X	X	X	30,000	Health section, Pratappur rural municipality	Health Office	
	X										X	X	X	X	-	Health section, Pratappur rural municipality		
												X	X	X	1,000,000	Health facility	Health Office; Health section, Pratappur rural municipality	
	X	X	X									X	X	X	1,500,000	Health section, Pratappur rural municipality		
Manage equipment and supplies required for storage like rack, pallet, fire extinguisher, thermometer etc.	X	X	X											500,000	Health section, Pratappur rural municipality	Health Office, Provincial government, supporting agencies		

HSS Objective 5: All essential medicines are available at all times in all health facilities within 2 years starting from FY 2078/79																	
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Strengthening	X	X	X	X	X	X					X	X	X	-	Health section, Pratappur rural municipality	Health Office, supporting agencies	
	X	X								X	X	X	-	Health section, Pratappur rural municipality			
	X	X								X	X	X	-	Health section, Pratappur rural municipality			
Classify all medicines and supplies available via local and province/federal level	X			X										-	Health facility	Health section, Pratappur rural municipality	
Advocate timely availability of medicine and supplies for medicines that are not available at local level		X			X									-	Health section, Pratappur rural municipality	Health Office	

HSS Objective 5: All essential medicines are available at all times in all health facilities within 2 years starting from FY 2078/79																	
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase			Budget (in NPR)	Responsible	Supporting agencies	Remarks	
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious					Emergency
Strengthening		X	X	X	X	X					X	X	X	-	Health section, Pratappur rural municipality	Health Office	
		X	X	X	X	X					X	X	X	-	Health section, Pratappur rural municipality	Health Office	
											X	X	X	500,000	Health section, Pratappur rural municipality	Health Office	
	X	X	X	X	X	X					X	X	X	200,000	Health section, Pratappur rural municipality	Health Office	
		X												-	Health section, Pratappur rural municipality		

HSS Objective 5: All essential medicines are available at all times in all health facilities within 2 years starting from FY 2078/79																		
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks	
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency					
Advocate for timely release of fund from province and federal level	X			X														
Conduct training/ refresher on eLMIS			X			X												
Conduct training/ refresher on procurement and quantification of medicines and supplies			X			X												
Conduct training/ refresher on proper management of storage of medicines and health supplies			X			X												
Make all health facilities technology friendly		X		X	X													
Support																		

HSS Objective 5: All essential medicines are available at all times in all health facilities within 2 years starting from FY 2078/79																	
Support	Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase		Budget (in NPR)	Responsible	Supporting agencies	Remarks	
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert					Serious
Support	Conduct orientation on health related rules & regulations, criteria, protocol and guideline to HFOMC			X								X		Health section, Pratappur rural municipality	Health facility, Health Office, supporting agencies		
Substitution	Appoint a separate pharmacist for management of medicines and health supplies storage												X	Supporting agencies	Health section, Pratappur rural municipality		
	Manage properly medicines and health supplies procurement, separate storage and transportation													Supporting agencies	Health section, Pratappur rural municipality		

HSS Objective 5: All essential medicines are available at all times in all health facilities within 2 years starting from FY 2078/79																	
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Result 2: Supplies of medicines will be effectively managed																	
Strengthening	X												X		Health section, Pratappur rural municipality		
													X	X	Health section, Pratappur rural municipality	Provincial Health Directorate, Department of Drug Administration, Health Office, supporting agencies	
														X	X	Health section, Pratappur rural municipality	Health facility, Health Office
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	Health facility; Health section, Pratappur rural municipality	Health Office	

HSS Objective 5: All essential medicines are available at all times in all health facilities within 2 years starting from FY 2078/79																		
Activities	FY 2078/79			FY 2079/80			FY 2080/81			Phase			Budget (in NPR)	Responsible	Supporting agencies	Remarks		
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious					Emergency	
Strengthening	X										X				-	Health section, Pratappur rural municipality	Health Office	
	X	X	X	X	X	X				X	X	X	X		-	Health facility; Health section, Pratappur rural municipality		
	X	X	X							X					50,000	Health section, Pratappur rural municipality	Health Office	



ANNEX

5.1 Annex 1: COMPOSITION OF THE STEERING COMMITTEE

S.N.	Position in SC	Organisation	Position in the Organisation	Name
1	Chair	<i>Pratappur</i> Rural Municipality	Chair	Rajkumar Sharma / Anju Kumari Chaudhary
2	Co-chair	<i>Pratappur</i> Rural Municipality	Co-chair	NA
3	Member Secretary	<i>Pratappur</i> Rural Municipality	Health Coordinator	Kundan Kumar Singh / Rishi Chaudhary
4	Member	<i>Pratappur</i> Rural Municipality	Chief Administrative Officer	Ghanshyam Gaha / Bhes Raj Khanal
5	Member	<i>Pratappur</i> Rural Municipality	Deputy Health Coordinator	Bijay Kumar Yadav
6	Member	United Mission to Nepal (UMN)	Programme Coordinator	Ishwor KC
7	Member	Indreni Development Forum	Programme Coordinator	Sushma Joshi
8	Member	Action Against Hunger, Nawalparasi	Sr. Programme Officer	Shirish Man Singh / Ranjan Kapali

5.2 ANNEX 2: PARTICIPANTS OF HSS WORKSHOP 1

Workshop name: Risk and Capacity Analysis
Date: 20 December 2019

S.N.	Full name	Gender Male (M) Female (F) Other (O)	Designation	Organisation	Contact no.
1	Raj Kumar Sharma	M	Chairperson	Pratappur RM	9857046052
2	Ghanashyam Gaha	M	Chief Executive Officer	Pratappur RM	9857080095
3	Sushma Joshi	F	Field Officer	Indreni Development Forum	9867301154
4	Santosh Poudel	M	Sr. AHW	Pratappur HP	9856055030
5	Mantosh Kumar Murau	M	HA	Thulo Khairtwa HP	9808725248
6	Lalit Chaudhary	F	Field supervisor	Pratappur HP	9805413750
7	Dol Kanti Chaudhary	F	ANM	Thulo Khairtwa HP	9811158779
8	Rishi Dev Chaudhary	M	Health Coordinator	Pratappur RM	9847041091
9	Anuradha Chaudhary	F	ANM	Pratappur HP	9804419017
10	Amarnath Pandey	M	NS	Health Office, Parasi	9815483228
11	Sudam Prasad Bishwokarma	M	Teacher	Subhakamana School	9817455337
12	Ishwar KC	M	Project Manager	UMN, Nawalparasi	9845204640
13	Dr. Sumit Sharma	M	Medical Officer	Jagannathpur PHC	9847201506
14	Gorakhnath Dhobi	M	OA	Pratappur HP	9821573123
15	Dil Bahadur Khadka	M	Field Manager	Action Against Hunger	9801241745
16	Sujay Nepali Bhattacharya	M	Head of N&H Department	Action Against Hunger	9801187510
17	Manisha Katwal	F	Sr. PO	Action Against Hunger	9801187513
18	Sanjay Kumar Chaudhary	M	Technical Officer	Action Against Hunger	9801241702
19	Sujana Silwal	F	Technical Officer	Action Against Hunger	9801241703
20	Ranjan Kapali	M	Sr. PO	Action Against Hunger	9801241742

5.3 ANNEX 3: PARTICIPANTS OF HSS WORKSHOP 2

Workshop name: Cause identification
Date: 20-21 January 2020

S.N.	Full name	Gender Male (M) Female (F) Other (O)	Designation	Organisation	Contact no.
1	Raj Kumar Sharma	M	Chairperson	Pratappur RM	9857046052
2	Anju Kumari Chaudhary	F	Vice-Chairperson	Pratappur RM	9857046053
3	Ghanashyam Gaha	M	Chief Administration Officer	Pratappur RM	9857080095
4	Hemendra Kumar Panjiyar	M	HFOMC Chairperson, ward-9	Pratappur RM	9857013742
5	Harendra Yadav	M	HFOMC Chairperson, ward-7	Pratappur RM	9857029958
6	Ishwori Prasad Tharu	F	HFOMC Chairperson, ward-2	Pratappur RM	9857080091
7	Sushma Joshi	F	Field Officer	Indreni Development Forum	9867301154
8	Dr. Goldi Jaiswal	F	MO	Jagannathpur PHC	9867427662
9	Santosh Poudel	M	Sr. AHW	Pratappur HP	9856055030
10	Mantosh Kumar Murau	M	HA	Thulo Khairtwa HP	9808725248
11	Lalita Chaudhary	F	Field Supervisor	Pratappur HP	9805413750
12	Ratan Lal Sharma	M	MI	Health Office, Parasi	9848024154
13	Janak Raj Khanal	M	Store Keeper	Health Office, Parasi	9848751081
14	Dol Kanti Chaudhary	F	ANM	Thulo Khairtwa HP	9811158779
15	Rishi Dev Chaudhary	M	Health Coordinator	Pratappur RM	9847041091
16	Anuradha Chaudhary	F	ANM	Pratappur HP	9804419017
17	Kaushal Kumar Yadav	M	AHW	Baidhauri HP	9864572816
18	Sanjay Kumar Sharma	M	AHW	Guthi Suryapura HP	9847266662
19	Upendra Kumar Koiri	M	HA	Guthi Suryapura HP	9845930285
20	Sunita Kushwaha	F	ANM	Somani HP	9844733512

S.N.	Full name	Gender Male (M) Female (F) Other (O)	Designation	Organisation	Contact no.
21	Amarnath Pandey	M	NS	Health Office, <i>Parasi</i>	9815483228
22	Sudam Prasad Bishwokarma	M	Teacher	Subhakamana School	9817455337
23	Ishwar KC	M	Project Manager	UMN, <i>Nawalparasi</i>	9845204640
24	Bhagawati Singh	F	FCHV	<i>Pratappur</i> RM	9867781971
25	Him Kumari Chaudhary	F	FCHV	<i>Pratappur</i> RM	9847461957
26	Dil Bahadur Khadka	M	Field Manager	Action Against Hunger	9801241745
27	Sujay Nepali Bhattacharya	M	Head of N&H Department	Action Against Hunger	9801187510
28	Manisha Katwal	F	Sr. PO	Action Against Hunger	9801187513
29	Sanjay Kumar Chaudhary	M	Technical Officer	Action Against Hunger	9801241702
30	Sujana Silwal	F	Technical Officer	Action Against Hunger	9801241703
31	Bishnu Poudel	M	Technical Officer	Action Against Hunger	9801241701

5.4 ANNEX 4: PARTICIPANTS OF HSS WORKSHOP 3

Workshop name: Diagnosis phase
Date: 29-30 September 2020

S.N.	Full name	Gender Male (M) Female (F) Other (O)	Designation	Organisation	Contact no.
1	Anju Kumari Chaudhary	F	Acting Chairperson	Pratappur RM	9857046053
2	Bhesh Raj Khanal	M	Chief Administrative Officer	Pratappur RM	9857080095
3	Hemendra Kumar Panjiyar	M	HFOMC Chairperson, ward-9	Pratappur RM	9857013742
4	Harendra Yadav	M	HFOMC Chairperson, ward-7	Pratappur RM	9857029958
5	Ishwori Prasad Tharu	M	HFOMC Chairperson, ward-2	Pratappur RM	9857080091
6	Sushma Joshi	F	Field Officer	Indreni Development Forum	9867301154
7	Santosh Poudel	M	Sr. AHW	Pratappur HP	9856055030
8	Mantosh Kumar Murau	M	HA	Thulo Khairtwa HP	9808725248
9	Lalit Chaudhary	F	Field supervisor	Pratappur HP	9805413750
10	Janak Raj Khanal	M	Store Keeper	Health Office, Parasi	9848751081
11	Rishi Dev Chaudhary	M	Health Coordinator	Pratappur RM	9847041091
12	Sanjay Kumar Sharma	M	AHW	Guthi Suryapura HP	9847266662
13	Upendra Kumar Koiri	M	HA	Guthi Parsauni HP	9845930285
14	Sudam Prasad Bishwokarma	M	Teacher	Subhakamana School	9817455337
15	Bhagawati Singh	F	FCHV	Pratappur RM	9867781971
16	Him Kumari Chaudhary	F	FCHV	Pratappur RM	9847461957
17	Shanti BK	F	WASH Coordinator	Pratappur RM	9857045994
18	Kadir Ali Ansari	M	Ward Chairperson	Ward - 08	9857013741
19	Dipkala Chaudhary	F	AHW	Pratappur HP	9866656534

S.N.	Full name	Gender Male (M) Female (F) Other (O)	Designation	Organisation	Contact no.
20	Binod Kumar Kohar	M	HA	Baidhauri HP	9845810501
21	Indra Prasad Lamichhane	M	Sr. AHW	Jagannathpur PHC	9857080405
22	Bishnu Prasad Pandey	M	AHW	Somani HP	9857067520
23	Krishna Prasad Pokhrel	M	Acting Chief	Health Office, Parasi	9857020348
24	Sher Singh Dahit	M	Field Manager	Action Against Hunger	9801241745
25	Sujay Nepali Bhattacharya	M	Head of N&H Department	Action Against Hunger	9801187510
26	Manisha Katwal	F	Sr. PO	Action Against Hunger	9801187513
27	Ranjan Kapali	M	Sr. PO	Action Against Hunger	9801241742
28	Sujana Silwal	F	Technical Officer	Action Against Hunger	9801241703
29	Bishnu Poudel	M	Technical Officer	Action Against Hunger	9801241701

5.5 ANNEX 5: PARTICIPANTS OF HSS WORKSHOP 4

Workshop name: Planning phase
Date: 05-06 October 2020

S.N.	Full name	Gender Male (M) Female (F) Other (O)	Designation	Organisation	Contact no.
1	Anju Kumari Chaudhary	F	Acting Chairperson	Pratappur RM	9857046053
2	Hemendra Kumar Panjiyar	M	HFOMC Chairperson, ward-9	Pratappur RM	9857013742
3	Harendra Yadav	M	HFOMC Chairperson, ward-7	Pratappur RM	9857029958
4	Ishwori Prasad Tharu	M	HFOMC Chairperson, ward-2	Pratappur RM	9857080091
5	Sushma Joshi	F	Field Officer	Indreni Development Forum	9867301154
6	Santosh Poudel	M	Sr. AHW	Pratappur HP	9856055030
7	Mantosh Kumar Murau	M	HA	Thulo Khairtwa HP	9808725248
8	Lalit Chaudhary	F	Field Supervisor	Pratappur HP	9805413750
9	Janak Raj Khanal	M	Store Keeper	Health Office, Parasi	9848751081
10	Ishwar KC	M	Project Manager	UMN Nawalparasi	9845204640
11	Rishi Dev Chaudhary	M	Health Coordinator	Pratappur RM	9847041091
12	Sanjay Kumar Sharma	M	AHW	Guthi Suryapura HP	9847266662
13	Upendra Kumar Koiri	M	HA	Guthi Parsauni HP	9845930285
14	Sudam Prasad Bishwokarma	M	Teacher	Subhakamana School	9817455337
15	Bhagawati Singh	F	FCHV	Pratappur RM	9867781971
16	Him Kumari Chaudhary	F	FCHV	Pratappur RM	9847461957
17	Shanti BK	F	Wash Coordinator	Pratappur RM	9857045994
18	Kadir Ali Ansari	M	Ward Chairperson	Ward - 08	9857013741
19	Dipkala Chaudhary	F	AHW	Pratappur HP	9866656534
20	Binod Kumar Kohar	M	HA	Baidhauri HP	9845810501

S.N.	Full name	Gender Male (M) Female (F) Other (O)	Designation	Organisation	Contact no.
21	Indra Prasad Lamichhane	M	Sr. AHW	Jagannathpur PHC	9857080405
22	Bishnu Prasad Pandey	M	AHW	Somani HP	9857067520
23	Krishna Prasad Pokhrel	M	Acting Chief	Health Office, Parasi	9857020348
24	Sher Singh Dahit	M	Field Manager	Action Against Hunger	9801241745
25	Sujay Nepali Bhattacharya	M	Head of N&H Department	Action Against Hunger	9801187510
26	Manisha Katwal	F	Sr. PO	Action Against Hunger	9801187513
27	Ranjan Kapali	M	Sr. PO	Action Against Hunger	9801241742
28	Sujana Silwal	F	Technical Officer	Action Against Hunger	9801241703
29	Bishnu Poudel	M	Technical Officer	Action Against Hunger	9801241701

5.6 ANNEX 6: PARTICIPANTS OF HSS WORKSHOP 5

Workshop name: Planning phase

Date: 26 November 2020

S.N.	Full name	Gender Male (M) Female (F) Other (O)	Designation	Organisation	Contact no.
1	Anju Kumari Chaudhary	F	Acting Chairperson	Pratappur RM	9857046053
2	Bhesh Raj Khanal	M	Chief Administrative Officer	Pratappur RM	9857080095
3	Hemendra Kumar Panjiyar	M	HFOMC Chairperson, ward-9	Pratappur RM	9857013742
4	Harendra Yadav	M	HFOMC Chairperson, ward-7	Pratappur RM	9857029958
5	Ishwori Prasad Tharu	M	HFOMC Chairperson, ward-2	Pratappur RM	9857080091
6	Santosh Poudel	M	Sr. AHW	Pratappur HP	9856055030
7	Mantosh Kumar Murau	M	HA	Thulo Khairtwa HP	9808725248
8	Lalit Chaudhary	F	Field Supervisor	Pratappur HP	9805413750
9	Rishi Dev Chaudhary	M	Health Coordinator	Pratappur RM	9847041091
10	Sanjay Kumar Sharma	M	AHW	Guthi Suryapura HP	9847266662
11	Upendra Kumar Koiri	M	HA	Guthi Parsauni HP	9845930285
12	Sudam Prasad Bishwokarma	M	Teacher	Subhakamana School	9817455337
13	Gita Chaudhary	F	MNF, SUA AHARA II	Pratappur RM	9847064276
14	Shanti BK	F	Wash Coordinator	Pratappur RM	9857045994
15	Kadir Ali Ansari	M	Ward Chairperson	Ward - 08	9857013741
16	Dipkala Chaudhary	F	AHW	Pratappur HP	9866656534
17	Binod Kumar Kohar	M	HA	Baidhauri HP	9845810501
18	Indra Prasad Lamichhane	M	Sr. AHW	Jagannathpur PHC	9857080405
19	Bishnu Prasad Pandey	M	AHW	Somani HP	9857067520

S.N.	Full name	Gender Male (M) Female (F) Other (O)	Designation	Organisation	Contact no.
20	Krishna Prasad Pokhrel	M	Acting Chief	Health office, <i>Parasi</i>	9857020348
21	Narayan Bhattarai	M	Officer	Health Office, <i>Nawalparasi West</i>	9849028180
22	Ram Hari Upadhyay	M	Ward Chairperson, Ward 6	<i>Pratappur</i> RM	9846291076
23	Diwakar Chaudhary	M	Ward Chairperson, Ward 3	<i>Pratappur</i> RM	9857047023
24	Tribhuvan Singh	M	Ward Chairperson, Ward 5	<i>Pratappur</i> RM	9857013738
25	Ashok Singh	M	Social Worker, Ward 5	<i>Pratappur</i> RM	
26	Jantri Prasad Barai	M	Ward Chairperson, Ward 4	<i>Pratappur</i> RM	
27	Narayan Chaudhary	M	Ward Chairperson, Ward 2	<i>Pratappur</i> RM	9867404856
28	Dina Nath Dhakal	M	Accounting Officer	<i>Pratappur</i> RM	9847086082
29	Kopila Shrestha	F	Field Manager	Green Tara Nepal	9857080841
30	Sher Singh Dahit	M	Field Manager	Action Against Hunger	9801241745
31	Sujay Nepali Bhattacharya	M	Head of N&H Department	Action Against Hunger	9801187510
32	Manisha Katwal	F	Sr. PO	Action Against Hunger	9801187513
33	Ranjan Kapali	M	Sr. PO	Action Against Hunger	9801241742
34	Sujana Silwal	F	Technical Officer	Action Against Hunger	9801241703
35	Bishnu Poudel	M	Technical Officer	Action Against Hunger	9801241701

5.7 ANNEX 7: HEALTH PROGRAMMES AND HEALTH INSURANCE SCHEMES IN NEPAL: COVERAGE, ELIGIBILITY, FINANCING, AND MANAGERIAL MECHANISMS

Criteria	Public system	National health insurance	Voluntary private insurance	Safe Motherhood Programme	Basic Health Care Package Service	Free Health Care	Enterprises private insurance by the employers	SSF	Improved Citizens' Service	Health insurance by Employment Provident Fund
Target population	All Nepalese citizens	All Nepalese citizens	Targeted population	Women in reproductive age and neonates	All Nepalese citizens	All Nepalese citizens particularly poor, vulnerable, and unreached population	Salaried workers associated to EPF scheme or workers of the enterprises	All formal and informal workers	All poor citizens	Target formal workers
Population covered or enrolled	Automatic	Around 75% of total population. Covering 42 districts out of 77 districts (Status on April 2019)	Less than 1% of total population	Automatic	Not started yet	72% of the target population	70 % of all The employees of the private enterprises receive some health benefit	Not started yet	8,250 poor citizens utilised services	Target 10 lakhs formal employees
Basis for coverage or enrolment	Automatic	Currently, voluntary enrolment (Mandatory according to the Health Insurance Act 2017)	Voluntary	Automatic	Automatic	Automatic	Voluntary	Mandatory	Automatic	Automatic

Criteria	Public system	National health insurance	Voluntary private insurance	Safe Motherhood Programme	Basic Health Care Package Service	Free Health Care	Enterprises private insurance by the employers	SSF	Improved Citizens' Service	Health Insurance by Employment Provident Fund
Benefits for entitlement	Immunisation, Nutrition, IMNCI, Family Planning, Safe motherhood and newborn health, PHC ORC disease control vertical programmes such as HIV/AIDS, tuberculosis, malaria, leprosy, polio, and so on. User fees exist for most curative services, but with exemptions for the poor, physically and mentally impaired people, senior citizens over 70 years	All services beyond free health care package worth NPR up to 200,000, including additional NPR 100,000 coverage for 8 listed chronic diseases and additional NPR 100,000 for every elderly population above 70 years with exception of negative list, according to the Health Insurance Regulation of 2018.	Benefit package varies according to the private insurance providers and insurance policies	ANC, Institutional delivery (normal, assisted and surgical); PNC perinatal care, including cash transfer to service user as transportation cost	Benefit package under development phase	Free OPD at the health posts, primary health care centres and up to 25-bedded public hospitals and up to 70 drugs provided free of cost.	Depends on Enterprises private insurance policy choice: private insurance policy, lump sum cash / reimbursement to the medical bills.	OPD, IPD, Diagnostics surgical, medical, including drugs and maternity care.	Chronic disease such as heart and kidney (renal failure) diseases, Alzheimer and Parkinson, cancer, head and spinal injuries up to NPR 100,000	Only IPD cases included worth up to NPR 100,000 and additional IPD cases worth up to NPR 1 million. OPD cases are excluded.

Criteria	Public system	National health insurance	Voluntary private insurance	Safe Motherhood Programme	Basic Health Care Package Service	Free Health Care	Enterprises private insurance by the employers	SSF	Impoverished Citizens' Service	Health insurance by Employment Provident Fund
Revenues sources	Tax funded (budget allocations), external/donor funds (Pool Fund), user charges	Tax funded - MoF provides annual block grant to subsidise premiums for poor and vulnerable population; Contribution collection from members (premium) NPR 3,500 per five family members per year (Health Insurance Regulation 2018)	Premium collection from enrollees	Tax funded	Tax funded	Tax funded	Enterprises internal revenues / profits	Payroll contribution collection from employer (20 percent) and employees (11 percent) And contribution collected from the informal sector worker voluntarily	Tax funded	Paid by EPF

Criteria	Public system	National health insurance	Voluntary private insurance	Safe Motherhood Programme	Basic Health Care Package Service	Free Health Care	Enterprises private insurance by the employers	SSF	Improved Citizens' Service	Health insurance by Employment Provident Fund
Pooling arrangements	Salaries are determined and paid centrally for the MoHP staff at all the levels of governments. Salaries are determined and paid locally for the locally hired staff. Municipalities (local government agencies) receive conditional grants, fiscal equalisation funds, matching funds specified for health that cover non-salary inputs. Pooled donor Assistance ("pool fund") goes directly to the central treasury.	Single pool at the national level managed by the Health Insurance Board (HIB)	Separate pool at private health insurance providers managed individually	Central budget reimbursement at the facility level by the MoHP	Central budget reimbursement at the facility level by the MoHP	Central budget pooled and distributed at the federal, provincial, and local governments (municipalities)	Enterprises managed individually (No pooling)	Single national pool for its members managed by the SSF	Central budget managed by the MoHP	The MoF pool the EPF funds on a government agency called Rastriya Beema Company Limited

Criteria	Public system	National health insurance	Voluntary private insurance	Safe Motherhood Programme	Basic Health Care Package Service	Free Health Care	Enterprises private insurance by the employers	SSF	Impoverished Citizens' Service	Health insurance by Employment Provident Fund
Purchasing mechanisms	There is no Purchaser provider split. The MoHP is responsible for national / specialised hospitals. Local governments are both owners and purchasers of health services at the provincial level and below.	Purchaser providers split HIB purchases the services from both the public and private providers on behalf of enrolled members.	Purchaser providers split. Individual Private insurance providers purchase the services from both the public and private providers on behalf of enrolled members.	Purchaser providers split (partial for private providers) The MoHP purchases the services from both the public and private providers.	There is no Purchaser provider split. Provincial and local governments are both owners and purchasers of the primary level care services at the health posts, primary health care centres, and public hospitals	There is no Purchaser provider split. Provincial and local governments are both owners and purchasers of the primary level care services at the health posts, primary health care centres up to 25 - bedded public hospitals	Enterprises purchase the health care services from providers on behalf of their employees or affiliates.	Purchaser providers split. SSF purchases the services from both the public and private providers on behalf of enrolled members.	There is no Purchaser provider split. The MoHP is both provider and purchaser of the eight chronic diseases from enlisted public hospitals.	EPF - Rastriya Beema Company Limited is The purchaser agent

Criteria	Public system	National health insurance	Voluntary private insurance	Safe Motherhood Programme	Basic Health Care Package Service	Free Health Care	Enterprises private insurance by the employers	SSF	Improved Citizens' Service	Health insurance by Employment Provident Fund
Provider payment	Input-based line item budgets	Fee-for-service Payments for the OPD package Case-based payment of IPD Fee for services for the diagnostics services except those not included in OPD and IPD package	Various practices at the individual insurance providers such as reimbursement of the bills of the enlisted services along with deductibles/co-payments based on the insurance policy	Capitation based payments from the MoHP Cash incentives depending on the level of facility and cases of delivery	Capitation based payments for the OPD by local governments	Capitation payments for the OPD by local governments	Conditional reimbursement for enterprises	Conditional reimbursement	Conditional grant Reimbursement up to NPR 100,000	Conditional reimbursement
Service delivery and contracting	All public health facilities; Private facilities for specific services (for example, dialysis); No explicit contracting takes place with public facilities	HIB contracts both public and providers	No specific contract by private insurance providers	Selected public and private facilities Explicit contracting takes place with public and private facilities	All public health facilities up to 25-bedded hospitals No explicit contracting takes place with public facilities	All public health facilities up to 25-bedded hospitals No explicit contracting takes place with public facilities	Few have explicit contracting with service providers		Public facilities for specific services No explicit contracting takes place with public facilities	In the case of EPF, Rastriya Beema Company Limited has contract with some service providers

Source: Bajracharya, B, and R. Karn. 2019. Social Health Protection Schemes in Nepal. Kathmandu: GIZ and WHO

