Bishnu Poudel for Action Against Hunger

Photo: Beneficiary at Manjariya Health Post for check up

HEALTH SYSTEM STRENGTHENING

RAMGRAM, DECEMBER 2020

ACTION AGAINST HUNGER
ACTION CONTRE LA FAIM

Ramgram Municipality
Office of The Municipal Executive
Parasi, Nawalparasi District
Lumbini Province, Nepal

Ramgram Municipality
Office Of The Municipal Executive
Parasi, Nawalparasi District
Lumbini Province, Nepal

Ref No.: 077/078-2571

Date: 08 February, 2021

PREFACE

Nepal is governed by the constitution, which came into effect in 2015 adopting federal system in the country. The constitution of Nepal 2015 recognises people's rights to health care as a fundamental right. In order to fulfil the requirement of the new constitution, Ramgram is committed to prioritise better health and nutrition for its people. The health section of the *Palika* has been working in close coordination and collaboration with Provincial government, Health Office of Nawalparasi West and health facilities for the implementation of health and nutrition services.

Health System Strengthening (HSS) exercise led by the *Palika* with technical assistance of Action Against Hunger | Action Contre la Faim (ACF) to understand better the 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 has been completed. This exercise was aimed at building the capacity of the *Palika* and its communities to engage in the health system governance and to contribute in building health system's resilience by allowing the system to prepare, absorb, adapt and transform from stresses/shocks.

Ramgram has developed this HSS action plan for the first time. I believe this health system strengthening action plan will guide the *Palika* to develop annual plan and budget of health and nutrition programme and implement it. I strongly belief this will ultimately improve and strengthen the health system of our *Palika* and benefit the wellbeing of the people residing in Ramgram.

Finally, I commit to reflect the developed multi-year action plan into the annual planning and budgeting of Ramgram and strongly urge all the relevant stakeholders to join hands together for the better functioning of the health system; strengthening it by prioritising health as a local development agenda to ensure need based delivery of health services leaving no-one behind.

Narendra Kumar Gupta
Mayor
Ramgram Municipality

Government of Province

Lumbini Province

Ministry of Social Development

Health Directorate

Health Office

Nawalparasi (West of Bardaghat Susta)

Date : 2077/10/25

FOREWORD

After promulgation of new Constitution in Nepal, several district level structures of different line ministries were dissolved/re-structured following decentralisation of power, and roles and responsibilities. Now, the jurisdiction of the health system has been shifted to the *Palika* with technical assistance from the Health Office. The new constitution in the country has also defined 'right to health' as a fundamental right and hence it is crucial as a development agenda for the *Palika*. In this regard, Ramgram led a Health System Strengthening (HSS) exercise with technical support from Action Against Hunger | Action Contre la Faim (ACF). The exercise identified strengths and weaknesses of the existing health system and created an excellent opportunity to identify and analyse the bottlenecks, and develop an action plan to guide the efforts of the health leadership at the *Palika*.

Health System Strengthening exercise generally tends to focus on the policy level intervention at the national and district level. For the first time, we had an opportunity to take on a HSS exercise at the *Palika* level. HSS Steering Committee including various stakeholders and supporting agencies led the exercise. The entire exercise was conducted in two phase which includes diagnosis phase and planning phase giving elements for advocacy at different levels. This exercise provided a platform to bring together all the stakeholders to hold rigorous discussion and consensus to assess various problems identified in the health system. The exercise outlined key bottlenecks that will now enable the *Palika* to take actions.

Lastly, I would like to express my gratitude to Action Against Hunger for technical support and all stakeholders involved for this valuable contributions. This innovative idea of engagement of locally elected governing bodies in the *Palika* has produced immense learning useful for further strengthening the health system and building resilience. We, Health Office would like to commit and support in all possible ways to take forward the developed action plans.

Krishna Prasad Pokharel
Acting Chief
Health Office, Nawalparasi West

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ACKNOWLEDGEMENT

Action Against Hunger | Action Contre la Faim (ACF) would like to thank all the parties and individuals, who were involved directly or indirectly in the success of the Health System Strengthening (HSS) exercise held in *Ramgram* municipality of *Nawalparasi* West of *Bardaghat Susta* district in between June 2019 to December 2020. Action Against Hunger extends its gratitude to the members of the HSS Steering Committee for their leadership, guidance and active participation at all stages of the exercise.

A special thanks to the assessment team including HSS technical support from the headquarter (France) Technical Advisor Health System Strengthening: Sarah Brousse and Regional Health and Nutrition Advisor (Asia): Brigitte Tonon; 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. Thanks to Philippe Hamel, Country Director for Nepal for his inputs. 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
COVID	Corona Virus Disease
CSOs	Civil Society Organisation
CTEVT	Council for Technical Education and Vocational Training
DAG	Disadvantaged Group
DDRC	District Disaster Relief Committee
DHIS	District Health Information Software
DoHS	Department of Health Services
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
FNCCI	Federation of Nepal Chamber of Commerce and Industries
FPAN	Family Planning Association of Nepal
FY	Fiscal Year

GoN	Government of Nepal
HA	Health Assistant
HFs	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 and 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
MSNP	Multi Sector Nutrition Plan
MoF	Ministry of Finance
MoHP	Ministry of Health and Population
MUAC	Mid Upper Arm Circumference
MuAN	Municipality Association of Nepal
NHEICC	National Health Education, Information and Communication Centre
NHSS	Nepal Health Sector Strategy

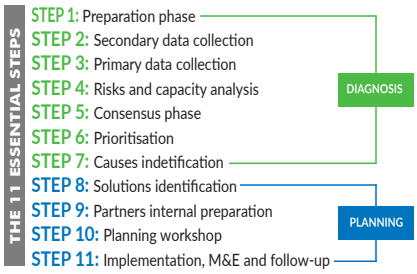
NHSSP	Nepal Health Sector Support Programme
NS	Nutrition Supervisor
NPR	Nepalese Rupees
OA	Office Assistant
O&M	Organisation and Management
ORC	Outreach clinic
OPD	Outpatient Department
OOP	Out-of-Pocket
OTCC	Outpatient Therapeutic Care Centre
PHC/ORC	Primary Health Care/Outreach
PHCC	Primary Health 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, Newborn 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
SNCU	Sick Newborn Care Unit
SSM	Supportive Supervision and Monitoring
TABUCS	Transaction based Accounting and Budget Control System
ToR	Terms of Reference
TWG	Technical Working Group
USAID	United States Agency for International Development
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

EXECUTIVE SUMMARY

Objective

The objective of the Health System Strengthening (HSS) exercise in *Ramgram* municipality of *Nawalparasi* West of *Bardaghat Susta* district 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 *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 for the development of their own roadmap for the coming years.

Structure of HSS methodology



The HSS methodology of Action Against Hunger version 3, was used to carry out this exercise under the leadership of the local health authorities, and in collaboration with all the health stakeholders of the *Palika*. 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, action plan is prepared in order to enable the health system to prepare, absorb, adapt and transform from shocks.

Five key bottlenecks

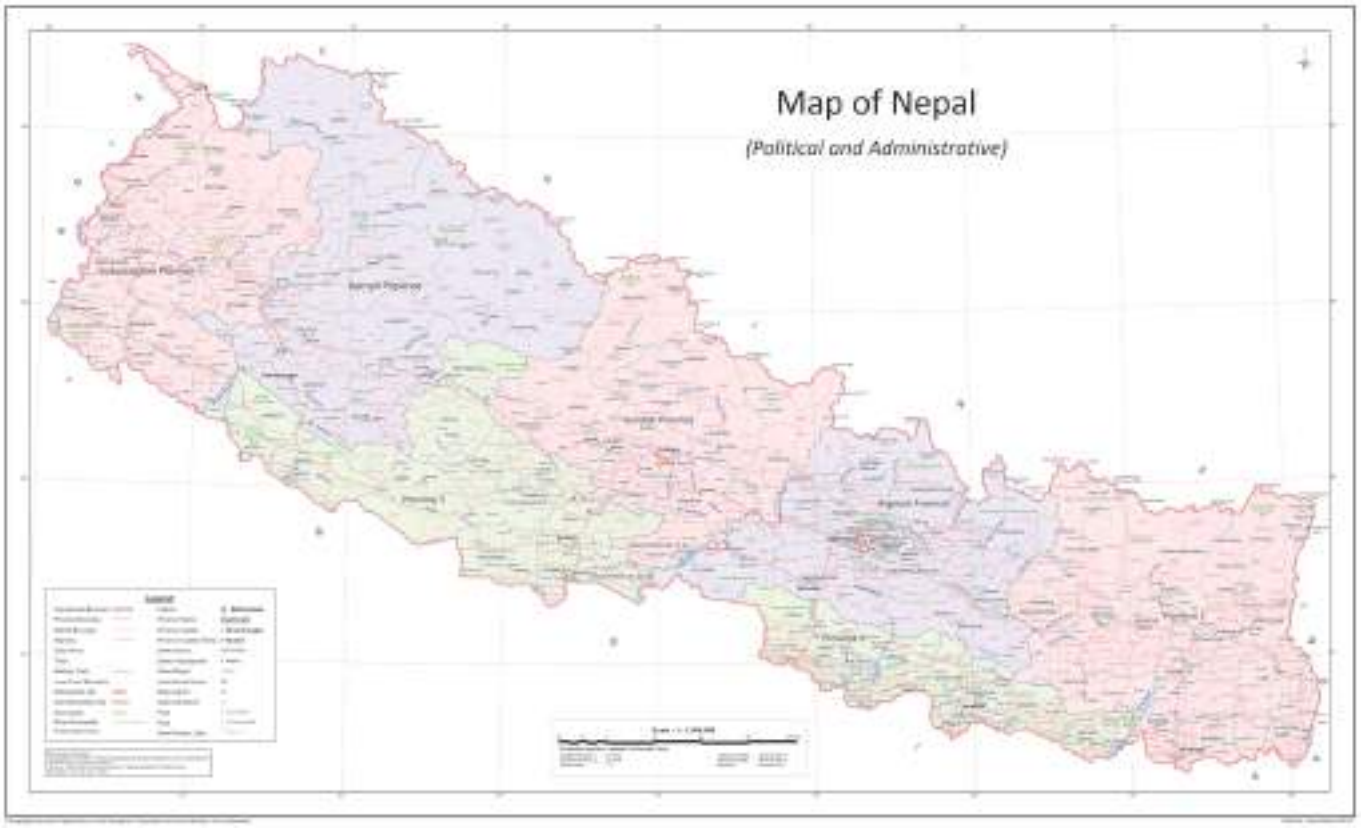
The HSS exercise outlined 5 key bottlenecks in the *Palika* which includes:

- Reports generated from Health Information System (HIS) are incomplete and of poor quality and the information is not used to take corrective actions
- Mechanism to analyse the health facility's performance does not exist and not implemented
- Health facilities are not equipped with infrastructure and equipment (medical and non-medical) according to the national norms
- Lack of sufficient, equitable, timely and updated (regularly trained / skilled) Human Resource at health facilities
- Essential health services of the continuum of Reproductive, Maternal, Neonatal and Child Health (RMNCH) services are not continuously available through the various levels of the health system

The HSS strategy

The results of 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 health authorities, the 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 INTRODUCTION: HEALTH SYSTEM STRENGTHENING



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 *Palika*). 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 (*Palika*). 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 and assets have been handed over to the *Palika*. Though the article 35 of the new Constitution of Nepal has defined the 'right to health', 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 *Palika* 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 HR at local levels. The government has designed and is implementing a decentralised budgeting system however, its effective utilisation remains a big question

with the limited capacity the *Palika* 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 *Palika* 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 *Palika* 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 (Step 4 of the approach proposed). 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 *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-annual *Palika* action plan with clear roles and responsibilities of all relevant actors
- Develop a resilience building approach

2 HEALTH SYSTEM STRENGTHENING: FROM DIAGNOSIS TO PLANNING METHODOLOGY

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 which are country based- top down model 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 published in 2013 followed by second version in early 2015. Recently 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 was formed to lead the whole process. Action Against Hunger facilitated the exercise and discussion with the relevant stakeholders within the *Palika* were involved to build 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 in leadership of the *Palika* to take ownership and operationalise the action plan developed. The approach comprises of 2 phases and 11 steps. It is 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

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

system with regards to the WHO six building blocks of the health system namely Governance; Financing; Service delivery; Health Workforce; Supply; and Health Information Systems. 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	• 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	• Secondary information regarding each building block and the context is collected.
3	Primary data collection	• Primary information regarding each building block is collected at the *Palika* level. • Secondary and primary information are analysed.
4	Risks and capacity analysis	Through a participatory approach: • Risks (type 1 and 2 shocks) and capacities are identified at the *Palika* level. • *Palika* thresholds are defined based on the workload and capacity of the *Palika*.
5	Consensus phase	Through a participatory approach: • 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	Through a participatory approach: • List of prioritised bottlenecks of the health system are outlined.
7	Cause identification	Through a participatory approach: • Interrelated causal trees of the prioritised indicators are built. • Immediate, underlying and basic causes are identified.
Planning phase		
8	Solutions identification	• Solutions trees are built. • 'HSS objectives' are identified for each solution.
9	Partners internal preparation	• The planning method is well understood by the partners. • Activities for the planning phase are pre-identified.
10	Planning workshop	Through a participatory approach: • A multi-year health action plan along with cost and resources is developed.
11	Implementation, M&E and follow-up	• 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 Mayor of *Ramgram* about the health system strengthening exercise, including its rationale, objective and importance. After getting consent from the Mayor of the *Palika*, Action Against Hunger team approached Health Office of *Nawalparasi* West and other stakeholders working in the *Palika*. After discussion with the different stakeholders, a Terms of Reference (ToR) for the steering committee (SC) along with proposed members for SC under the leadership of Mayor was done. 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

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

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

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

S.N.	Position in SC	Organisation	Position in the Organisation
1	Chair	*Ramgram*	Chief/Mayor of the *Palika*
2	Co-chair	*Ramgram*	Chief Administrative Officer
3	Member Secretary	*Ramgram*	Health Coordinator
4	Member	*USAID / SUAAHARA II Project*	Programme Coordinator
5	Member	*Nepal Red Cross Society (NRCS), Nawalparasi West*	President
6	Member	Family Planning Association Nepal (FPAN)	Manager
7	Member	Health Office, *Nawalparasi* West	Chief
8	Member	Federation of Nepalese Chamber of Commerce and Industries (FNCCI), *Nawalparasi* West	Member
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 municipality 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 in respect to Action Against Hunger's HSS methodology. A brief description of the two workshops of the diagnosis phase are as follows:

STEP 1: Preparation phase
STEP 2: Secondary data collection
STEP 3: Primary data collection
STEP 4: Risks and capacity
STEP 5: Consensus phase
STEP 6: Prioritisation
STEP 7: Causes indetification

DIAGNOSIS

- 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 situation.
- Workshop 2 – Diagnosis workshop (Steps 5 to 7): The workshop provided an opportunity for 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 *Amarban* Health Post, *Ramgram*

3.1 DATA COLLECTION AND INDICATOR SCORING

Prior to data collection, an orientation on HSS was held on 14 July 2019. The orientation was given to all the SC members about HSS exercise, its methodology and importance. The aim of the orientation was to familiarise the SC members about HSS. In order to benefit from an evidence-based approach, primary and secondary data were collected to properly inform the discussions 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, access to essential medicines, 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 (HP) and hospital. In total, there are one hospital and eight HPs in the *Palika*:

Table: List of health facilities for primary data collection

S.N.	Name and type of health facilities
1	*Prithvi Chandra Hospital*
2	*Manjariya HP*
3	*Hakui HP*
4	*Devgaun HP*
5	*Amarban HP*
6	*Unwach HP*
7	*Sukrauli HP*
8	*Jammuwad* HP
9	*Amraut* HP

The information generated from the primary and secondary data as well as knowledge and experiences of the stakeholders of the *Palika* health system was used to score a self-assessment tool during the diagnosis workshop. Scoring was done after discussions and consensus between all the various actors of the health system at *Palika* level. The self-assessment tool consisted of 113 indicators used to score each building block to assess the present state of *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 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:

Table: Colour coding for the scoring of indicators

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

Manisha Katwal for Action Against Hunger

Photo: Individual interview with Ward chair of ward no. 16, *Ramgram* Municipality

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 crisis; 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 government, 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 situation. Building resilience is context-dependent needing assessment of system capacities and response. Following this, a workshop for risk and capacity analysis of health system and defining 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 induces 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 a lot its resilience capacities, embedded in the 6 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 hospital), 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 hospital caseload, patients coming to the outpatient and emergency were considered (in-patients were included in the outpatients data).

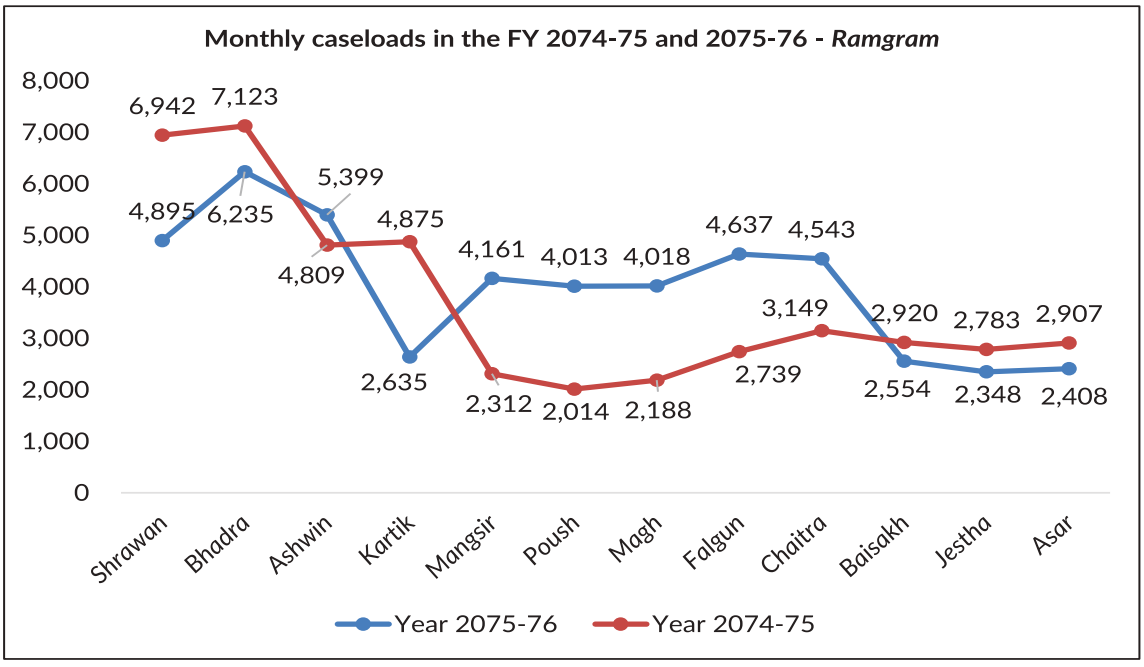


Figure: Monthly caseloads in two fiscal years (2074-76) in Ramgram municipality

The caseload information showed that the cases took peak in few months in both the fiscal year however, there was high discrepancies in few months. The caseload was high in the month of *Shrawan* and *Bhadra* and subsequently low in the month of *Ashwin* and *Kartik*. The increase in the caseload during *Shrawan* 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 month, with more food availability and beneficiaries reluctant to visiting health facilities.

The main diagnosis were:

- Other diseases and injuries are mostly related to headache and diseases and injuries pyrexia of unknown origin (PUO)
- Communicable water borne diseases are mostly represented by diarrhoea cases. The prevalence of the cases goes up during raining season when water sources are more likely to be contaminated, and the hygiene practices are poor.
- The data from the last two fiscal year 2074-76

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

showed that the top three diseases in *Ramgram* was surgical problems with an average caseload in last two FY 11,367; followed by cataract cases and headache. According to the available data, other prominent morbidity in the *Palika* were diarrhoea, musculoskeletal pain, Upper and lower Respiratory Tract Infection, gastritis, refractive error cases.

- The caseload information from the secondary analysis found that the average total number of cases is 46,304 per year, with an average of maximum 6,679 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 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. The idea is to encourage each HF 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.

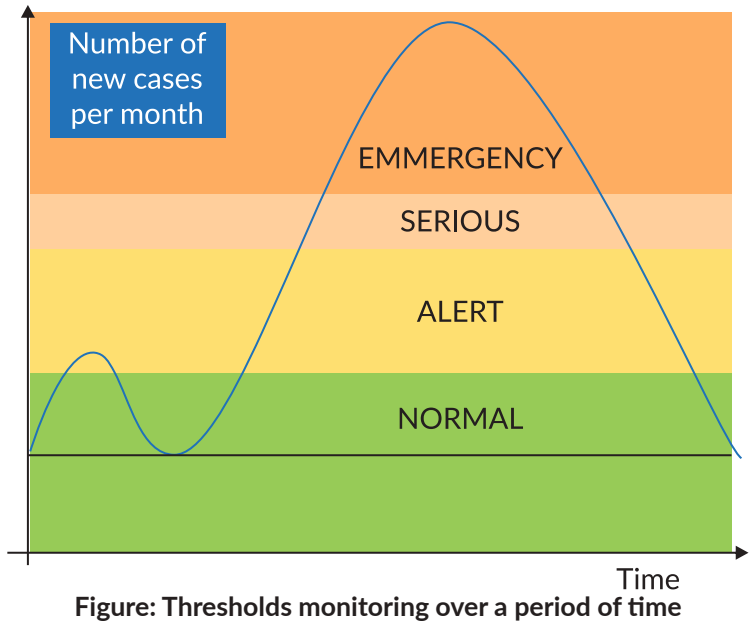


Figure: Thresholds monitoring over a period of time

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 municipality could be. These various phases will help the municipality to get better organised for type 1 shocks. The thresholds were calculated, for both HP and hospital assuming 25 working days per month, from 10:00 am to 05:00 pm, with full staff available at these hours.

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	2,000	2,400	2,880
Hospital (both OPD and IPD)	9,100	10,920	13,104
Palika	14,000	16,800	20,160

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: Type 2 shock, its effect on building block and its magnitude

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, strike, development works, transfer of health workers, rain	Festival, Flood, festival, strike, development works, transfer of health workers	Festival, Strike, development works, transfer of health workers	Festival, agricultural work load, strike, development works, transfer of health workers	Agricultural work load, strike, development works, transfer of health workers	Cold wave, strike, development works, transfer of health workers	Cold wave, strike, development works, transfer of health workers	Strike, development works, transfer of health workers	Excessive heat, agricultural work load, strike, development works, transfer of health workers	Excessive heat, strike, development works, transfer of health workers	Excessive heat, agricultural work load, strike, development works, transfer of health workers	Flood, excessive heat, agricultural work load, strike, development works, transfer of health workers, rain
Effects	Service delivery, Financing, HR, Logistics, Information management	Service delivery, Financing, HR, Logistics, Information management	Service delivery, Financing, HR, Logistics	Service delivery, Financing, HR, Logistics	Service delivery, HR	Service delivery, HR	Service delivery, HR	Service delivery, HR	Service delivery, HR, logistics	Service delivery, HR, logistics	Service delivery, HR, logistics	Service delivery, Financing, HR, Logistics, Information management
Shock magnitude (High (3) Medium (2) Low (1))	2	2	2	2	2	2	2	2	2	2	2	2

In *Ramgram*, access to many 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 resulting in affecting service delivery. Due to ongoing re-structuring of health workers, transfer of health workers is evident and fulfilment of all the sanctioned position is not complete. This has resulted in negative effect on service delivery, HIS and HR. Also, throughout the year, development works i.e. construction of roads and infrastructures has led to impact the financing (less priority for health sector). The different type of Type 2 shock identified during the workshop and its ranking as per severity of adverse effects are as follows:

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

Month/Type of shock	Excessive heat	Flood	Cold wave	Festival	Agriculture workload	Strike	Development work	Transfer of health staffs	Rainfall
Jul (*Shrawan*)		2				1	1	2	2
Aug (*Bhadra*)		2		2		1	1	2	
Sep (*Ashwin*)				2		1	1	2	
Oct (*Kartik*)				2	1	1	1	2	
Nov (*Mangsir*)					1	1	1	2	
Dec (*Poush*)			1			1	1	2	
Jan (*Magh*)			1			1	1	2	
Feb (*Falgun*)						1	1	2	
Mar (*Chaitra*)	1				1	1	1	2	
Apr (*Baisakh*)	1					1	1	2	
May (*Jestha*)	1					1	1	2	
Jun (*Asar*)	1	2			1	1	1	2	2

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 they were accountable to various units of MoHP but following local election in May and June 2017 after a gap of 20 years, the local government i.e. *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 *Palika* level also comes under the jurisdiction of the *Palika*.

Manisha Katwal for Action Against Hunger

Photo: Individual interview with Acting Medical Superintendent

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*

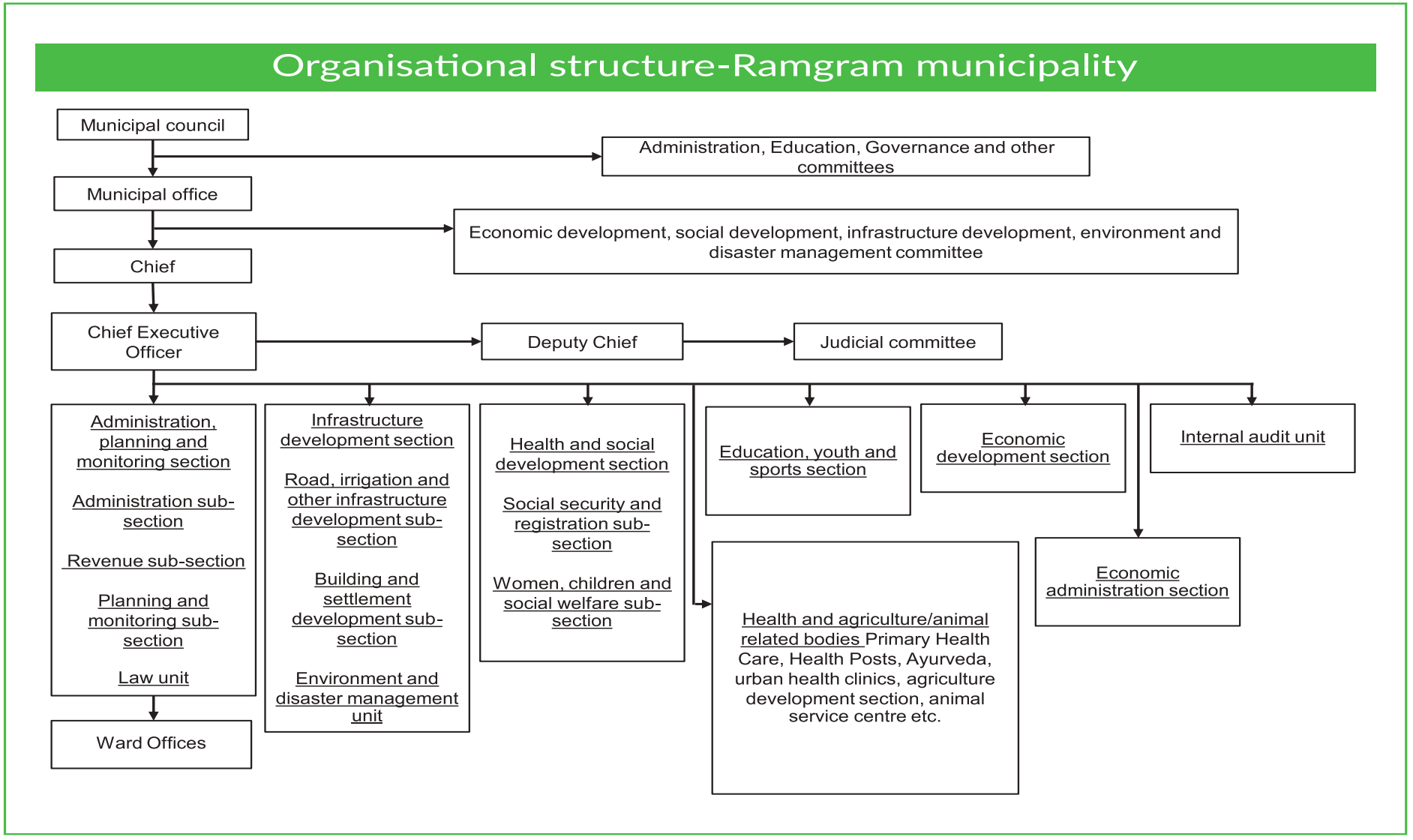


Figure: Organogram of Ramgram municipality

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

RESULTS OF PRIMARY DATA ANALYSIS FOR 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).

Figure: Organogram of Health Office, Nawalparasi West

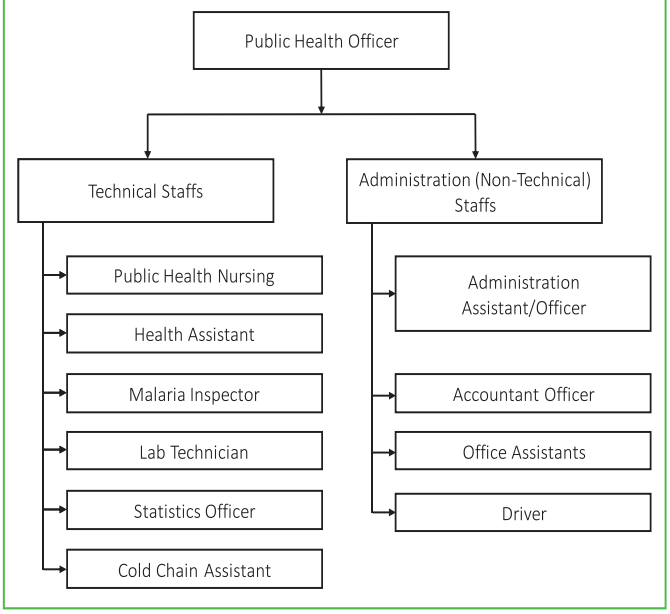


Table: Strengths and weaknesses of Governance building block in *Ramgram*

Strength	Weakness
▪ Existence of Health Facility Operation and Management Committee (Hospital Development Board in case of the hospital) in all health facilities (HFs) ▪ There are clearly defined roles and responsibilities of all health workers in all the health facilities. ▪ Regular meetings held for planning, monitoring and evaluation chaired by the *Palika* ▪ There is availability of information system for service users in HFs but need to be updated (available in 78% of the HFs). ▪ There is coordination mechanism with District Disaster Relief Committee (DDRC) and Rapid Response Team activates to respond during emergency. ▪ Financial resources coming from donors/partners for interventions are harmonised/coordinated by the *Palika*.	▪ Unavailability of protocols and clinical guidelines in health facilities (available only in 67% of the HFs, not used even if available) ▪ Unavailability of annual action plan in majority (88%) of the HFs ▪ No involvement of facility's in charge in annual action plan formulation (77% of the HFs are not involved) ▪ Unavailability of contingency plan for emergency in health facilities except Unwach HP, hospital and at the *Palika* level ▪ No meetings held between the community and HF in majority of the HFs. 78% of the HFs reported that the meetings are not held with the community. ▪ There is no mapping of actors (I/NGOs) working in health sector at the *Palika* level. ▪ No exit plan prepared by actors (I/NGOs) in consultation with the *Palika* before exiting the *Palika*. ▪ No mechanism set to receive feedback and complaint from the community, Health Workers (HWs), Female Community Health Volunteers (FCHVs), beneficiaries etc.

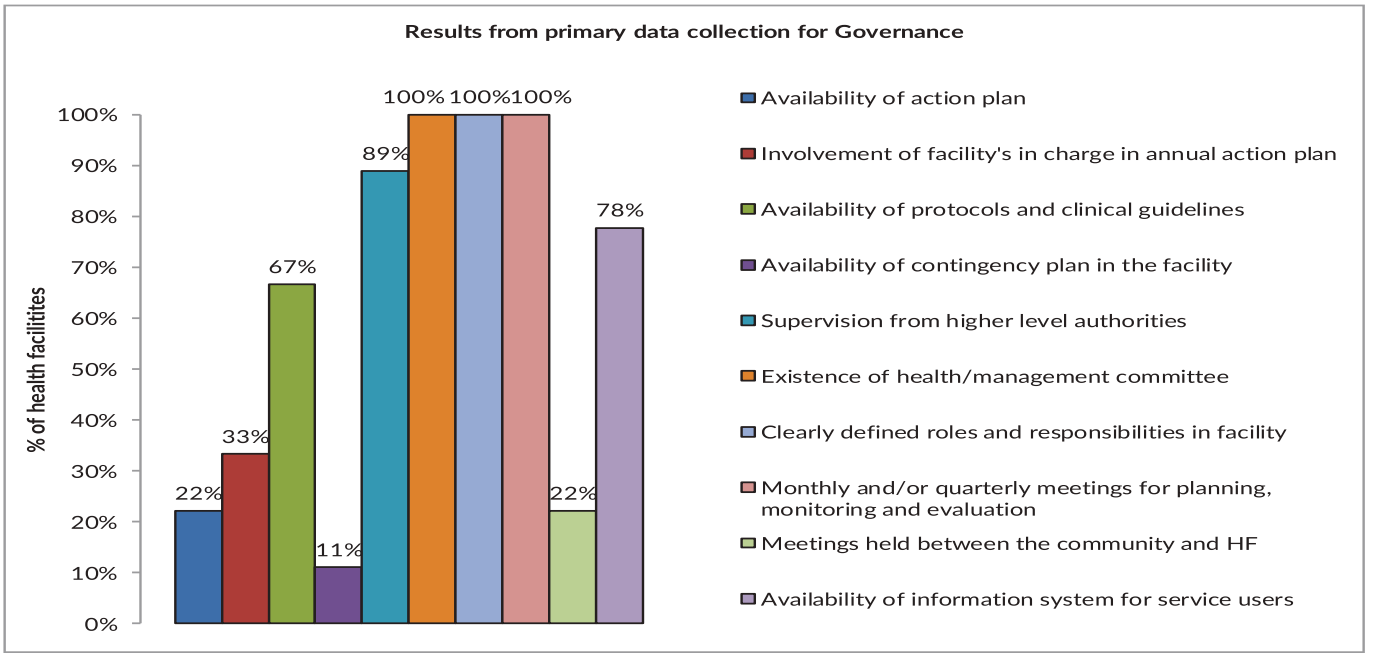
During the diagnosis workshop, the governance building block was qualified as "Adequate", with a score of 1.70 out of 3. The good scoring of the Governance shows that the regulations framework is present and satisfactory at the national and *Palika* levels, but the challenges will mostly reside in the implementation and accountability of this governance framework at the *Palika* level. The main policies, regulations, strategies and plans are developed by the federal level and disseminated to the district, the *Palika* and the HF levels for implementation.

A pre-defined organogram is available, however due to restructuring/staff adjustment, clearly defined roles and responsibilities at various levels of the health system is partial and not completely followed. 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 to the other levels of the health system (district and beyond). Despite the presence of an implementation strategy of the health plans and policies, the implementation itself is not properly done due to a lack of resources availability. 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*. 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.

Table: Results of scoring for the Governance building block

Governance		1.70
1	Policy formulation and planning	1.58
2	Information/assessment capacity	1.50
3	Social participation and system responsiveness	1.88
4	Accountability	1.40
5	Regulation	2.33

Supervision and monitoring from the Health Office, provincial and federal levels are not regular with no feedback for corrective actions. There is action plan available for hospital only but there is no engagement of stakeholders like the *Palika* and supporting agencies in formulation of the action plan. This is also maybe due to the fact that the hospital is under the Provincial government. Annual reports are developed but there is no strategy to disseminate it to wider stakeholders including the *Palika's* population. There is a contingency plan at the *Palika* level and Rapid Response Team (RRT) works in coordination with District Disaster Relief Committee (DDRC) but each health facilities under the *Palika* do not have their own contingency plan. Donors and partners are aligned with National Health Sector Support Plan (NHSSP) and Multi-Sector Nutrition Plan (MSNP) however, collaboration with Civil Society Organisations (CSOs) needs to be strengthened. An exit strategy is not prepared and shared with the *Palika* before departing/ exiting from the *Palika*.



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 capitalised and sometimes shared during annual review but not shared in wider community. There is a clear and comprehensive strategy of IEC/BCC developed at 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 health sector, but the report is not broadly disseminated. Beside this, a financial report is also prepared, it is neither broadly disseminated nor made available to the public. 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 *Palika's* (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 *Ramgram*

Strength	Weakness
▪ Health facilities receive funding envelope from the *Palika* which is sufficient to deliver basic health services. ▪ There is presence of free health care policy in HFs. ▪ There is presence of person in charge of the fund management within the HF.	▪ There is no sufficient finance and process to deal with Type 1 and Type 2 shocks at the *Palika* level. ▪ There is no solidarity fund for the most deprived/ poor people at the *Palika* level. ▪ There is no involvement of community in the financial management of the HF. ▪ Budget allocation not done based on priority of the programme by the *Palika*. There is no analysis of the need for each programme. ▪ There is no timely release of allocated fund from the federal government to the *Palika*. ▪ Unavailability of other funding sources (than government's Red book and other) at the *Palika* for health programmes/services. 56% of the HFs reported no other funding sources available in the health.

The financing building block obtained a score of 1.21 out of 3, meaning that it is present but not adequate. There are funding coming from government and donors, however these funds are not sufficient. There is no system of basket fund and hence there is need for a more coordinated and systematic financial mechanism in place.

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.*

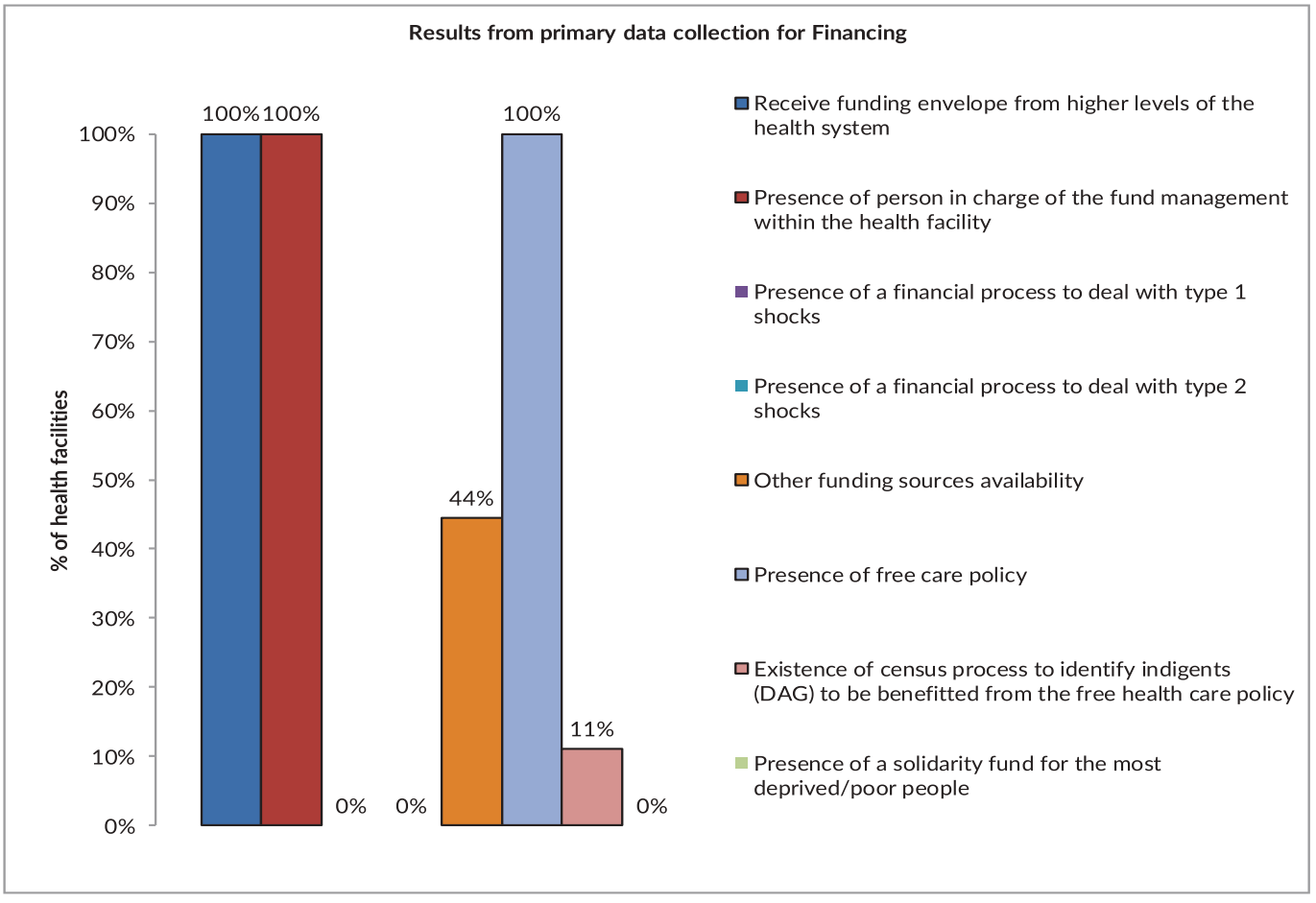
Since the *Palika* is mostly implementing the activities defined and budgeted, an analysis of financial gap is not key and is not performed. However, there is a system called Transaction based Accounting and Budget Control System (TABUCS) which allows to record all financial activities and can be used to do gap analysis.

There is no system of joint financing. 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. Budget are allocated for annual activities of the *Palika* and the budget are insufficient. The annual plans are not developed as per priority and budget hence are not allocated in the similar way. Regular activities of RMNCH are getting funds however, no new activities are developed or planned. No funds are allocated to the *Palika* health authorities dedicated and sufficient for preparing and coping with shocks 1 and 2. Hence, during shocks, the *Palika* often works on ad hoc basis, budget explored and allocated as and when required.

Table: Results of scoring for the Financing building block

Financing		1.21
6	Pooling and allocation of financial resources-Government budget formulation and allocation	1.56
7	Joint financing	0
8	Universal access to health care	2

Every four months, *Palika* releases fund to all health facilities and Health Facility Operation Management Committee (HFOMC) manages the fund for the health facilities. The budget released by the *Palika* is not adapted nor 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 and ensures 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 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 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 changed 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. 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. There is no new strategy developed or updated. Also, these strategy has not been aligned to develop HR strategy at *Palika* level too. National Health Training Centre under Ministry of Health and Population is responsible to oversee all health training at all three government tiers i.e. federal, provincial and *Palika* level through appropriate and quality training needs assessment, training delivery, monitoring, evaluation, post training follow up and research.

The Human Resources Strategic Plan 2011-2015 has been followed in the past years, it has not been updated to the present context, but it 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, strong biases are observed along the process, which does not allow 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) available at the federal level however, not updated regularly and is rarely used. *Palika* level HR information management system is yet to be developed.

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 *Ramgram*

Strength	Weakness
▪ There is well managed workload among health staffs in the health facilities ▪ The health staffs are motivated and satisfied due to new adjustment/transfer of health staff to their own place. ▪ The HWs get transportation and per diem during trainings, workshops, supervision and monitoring visits, which are motivating to them. ▪ There is presence of skilled and competent health workers in the health facilities.	▪ All sanctioned positions for health workers per HF is not fulfilled in almost all HFs. ▪ There is no provision of additional staff in the health facility during peak times. ▪ There is no system of assessing performance of human resources to allow progress in salaries and benefits. ▪ There is no scheduled and planned training for health workers. They are conducted as and when necessary/coming. ▪ Training for health workers are not conducted for the management of admission peaks. ▪ There are no regular monitoring, supervision and feedback to health facilities by higher authorities like Health Office, Provincial and Federal levels. ▪ Job descriptions of health workers not in use (33% of the health facilities mentioned).

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

Table: Results for the Human Resources building block

Human Resources		1.70
9	Policies	1.33
10	Planning	2.00
11	Performance management	2.50
12	Training and education	1.44

The human resource building block has been scored as 'adequate' with a score of 1.70 out of 3. The scoring shows that system and process exist and are mostly defined, but their implementation is limited. Management of HR as per the requirement taking seasonality into account is not done, thus, it does not allow to respond adequately to the needs of the *Palika*. Indeed, a HR management system, which includes performance, recruitment, promotion, transfer exists in the *Palika* but it is partially implemented and not always well used. Health workers are recruited through 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. Sometimes 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 trainings 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 and other institutions however, all services are not covered.

The number of staffs was not adequate and no scale up took place during the year. 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, there is no plan to mobilise staffs adequately.

A lack of regular supervisions of the HFs has been recorded. HFs are not visited by the *Palika* and province for supervisions. There are few visits done by Health Office which is not regular too. 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 (MoF).

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 that will 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 days training for newly recruited staffs but, these trainings depend on the budget 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.

Supply

3.2.5 SUPPLY

According to the WHO framework for health systems [11], 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, For a 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 (HP) 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 medicine and supplies with varied threshold. At federal level, procurement of drugs required by all province and *Palika* 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 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 coordinated 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 (DoHS) monitor the flow of commodities at the federal level, Provincial Health Logistic Management Centre at the Province level and *Palika* at the local level. During 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 *Ramgram*

Strength	Weakness
▪ There is possibility to order and obtain medicines in case of stock out and there is capacity for storage in all health facilities. ▪ There is availability of handbooks/manuals for medicine and nutritional inputs stock management in all HFs. ▪ There is availability of essential equipment e.g. thermometer, Blood pressure meter, Stethoscope etc. in all health facilities. ▪ There is possibility to order and obtain additional equipment quickly in case of shocks/emergency by health facilities via the *Palika* (in 75% of HFs).	▪ There is no procurement plan developed by all the health facilities taking into account seasonal shocks. ▪ Unavailability of stock card in health facilities and if available not in use (unavailable in 89% of HFs) ▪ There is no assessing system for quality test of medicine and supplies. ▪ Unavailability of protection devices e.g. Fire extinguisher (unavailable in 78% of HFs), radiology and laboratory equipment (unavailable in 89% of HFs) ▪ Insufficient medicines at HFs (50% of HFs reported insufficient medicines) ▪ There is long procurement procedure for buying medicines and supplies/equipment. ▪ There are limited essential medicines available at HFs, hence service users prefer to go to private clinics.

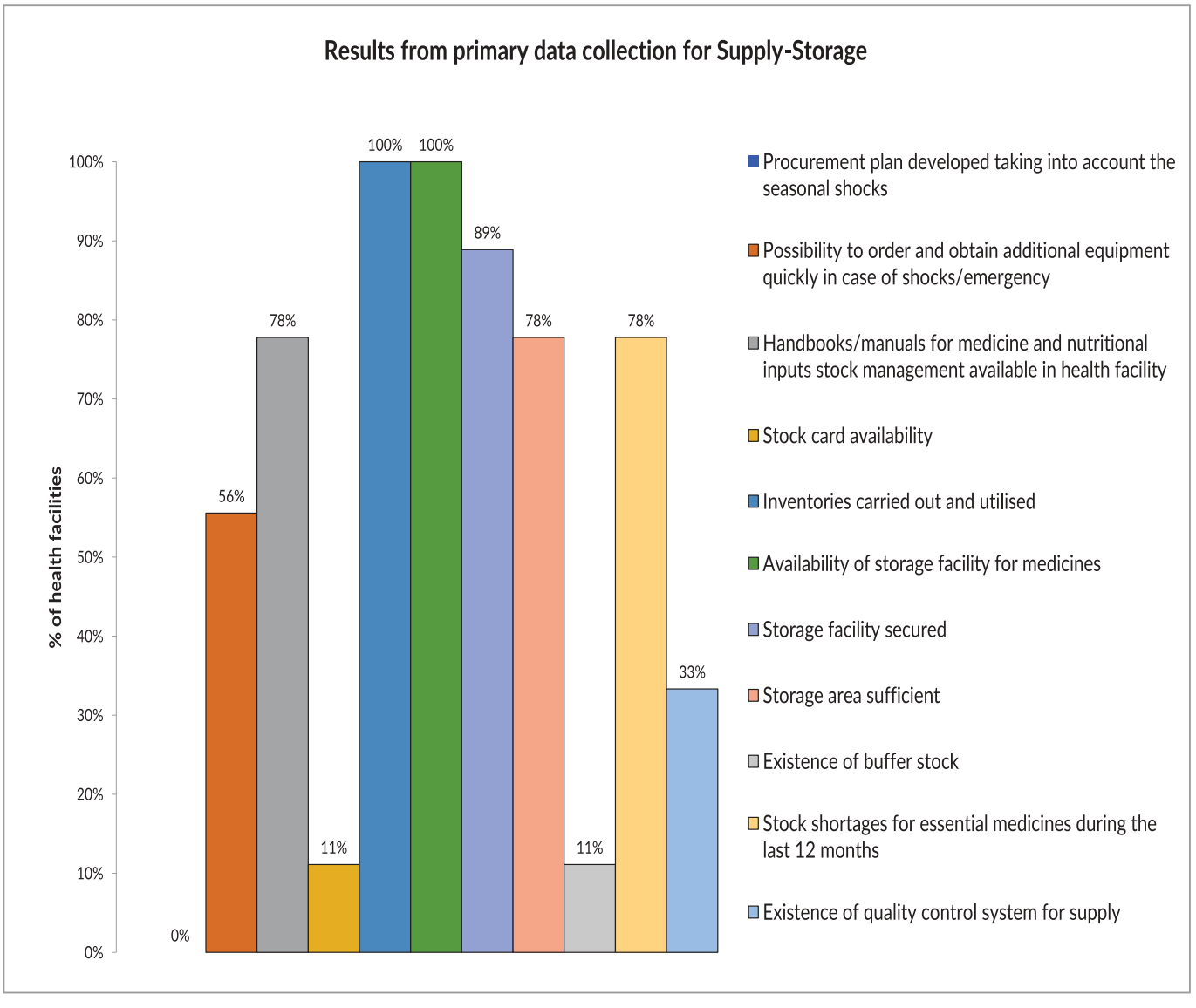
11 *Everybody's business. Strengthening health systems to improve health outcomes. WHO's framework for action. Geneva, World Health Organization, 2007*

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

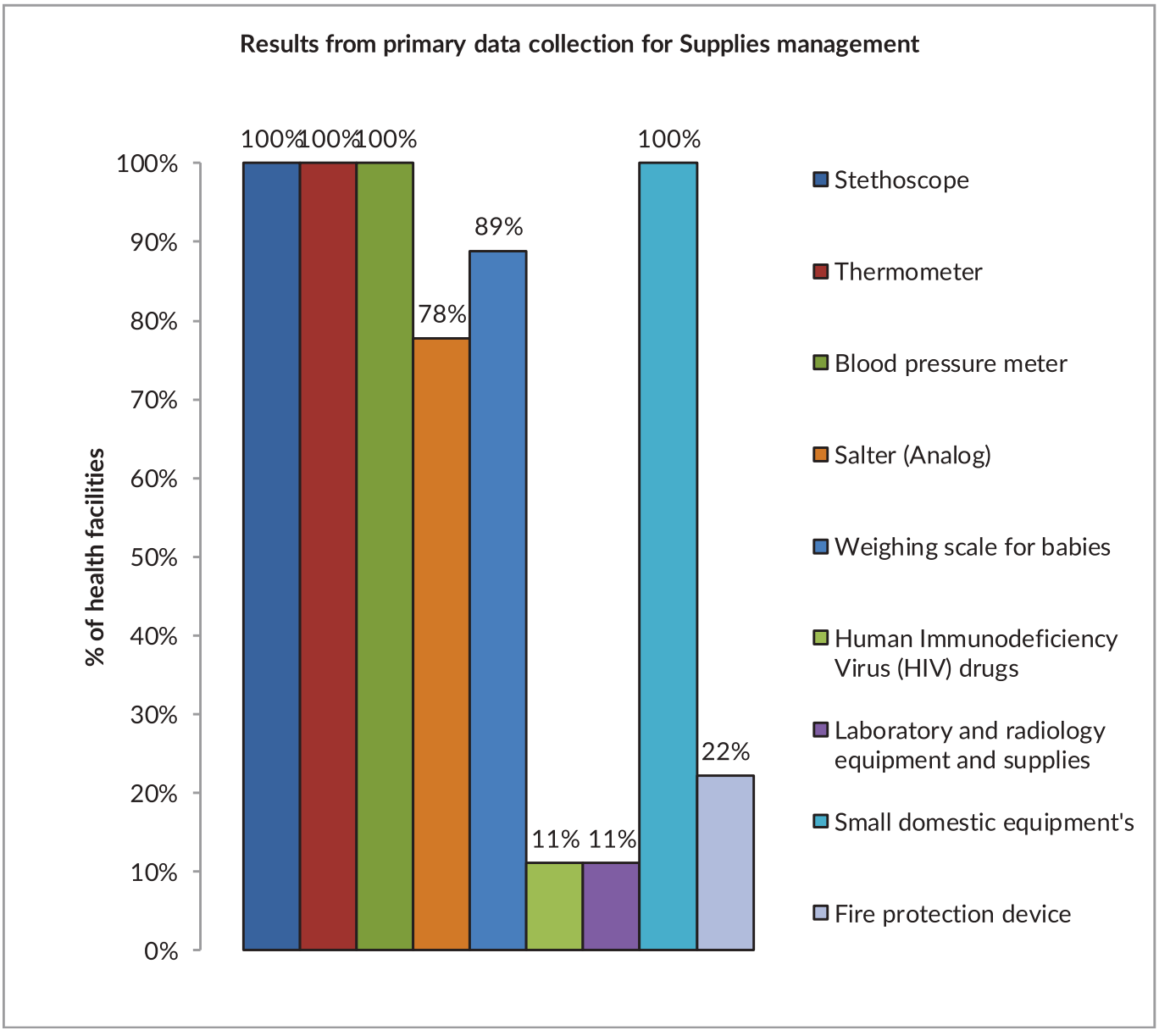
The supply building block obtained a score of 2 out of 3, which means that it is 'adequate.' This shows that several aspects of this building block has a good functioning such as LMIS and a well-defined supply chain. **Table: Results for the Supply building block**

Supply		2.00
13	Pharmaceutical policies, laws and regulations	1.83
14	Effective implementation of supply	2.22
15	Joint supply management	1.67

There are some issues in the implementation of LMIS/ supply chain management for instance, long procurement process or anticipation of stock outs, which do not take into account seasonality. National Drug Policy 1995 is available but is outdated. There is no medium term procurement taking into account shocks however, these are partially used for supply management. Drugs are procured from enlisted certified companies however, no mechanism exist to check quality and not conducted in a regular basis. Guidelines on the storage and management of drugs and other supplies exist but are partially applied For example, the storage area for the supplies is mostly insufficient (50%), storage facility are not secured (25%). There is no buffer stock available in all health facilities (unavailable in 75% of the HFs) and no stock management (50%) is done at the *Palika* level, hence Health Office is acting as warehouse. In 50% of the health facilities, stock out of medicines were experienced in the last 12 months. The reason behind these was mainly due to long procurement process, fund availability and no buffer stock.



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. No stock card in maintained at health facilities level and supplies are requested on need basis with no proper scheduled supply. During any shock, the *Palika* has the ability to procure drugs but with limited threshold and should request Province Medical Store for larger supplies in support of 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' 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 there is currently lack of health facilities. However, this will take time and these structures are yet to take shape in wards of *Ramgram*, 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).

Photo: Key Informant Interview (KII) of mother with under five years child in Ramgram municipality

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 *Ramgram*

Strength	Weakness
▪ There is availability of essential infrastructure and equipment for service delivery in health facilities (e.g. observation room (available in 100% HFs), waiting area (100% HFs), functional toilets (100% HFs), cold chain (78% HFs) etc.). ▪ Beneficiaries do not need to wait for long time to receive health services in the health facilities. ▪ Regular health camps are organised by the *Palika* and/or health facilities. ▪ There is availability of community based health services focusing on hard-to-reach/remote areas (e.g. Outreach clinics). ▪ There is good relation between different HFs in the *Palika*.	▪ Few villages (four) far away from health facilities from which it is difficult to seek services. ▪ There is no Follow-Up of referred patients to higher/ other institutions by the health facilities. ▪ There are limited essential medicines available at HFs, hence service users prefer to go to private clinics. ▪ There is no mechanism to check the quality of services provided by the health facilities and receive feedback and complaint from the community. ▪ Facilities such as drinking water point (not available in 56% HFs), handwashing areas for caregivers (not available in 77% HFs) not available within the health facilities.

Service delivery obtained a score of 1.55 out of 3 which means 'adequate.' All the sub categories except availability and continuity of care and coverage, and access to RMNCH services scored 'Adequate'.

Table: Results for the Service delivery building block

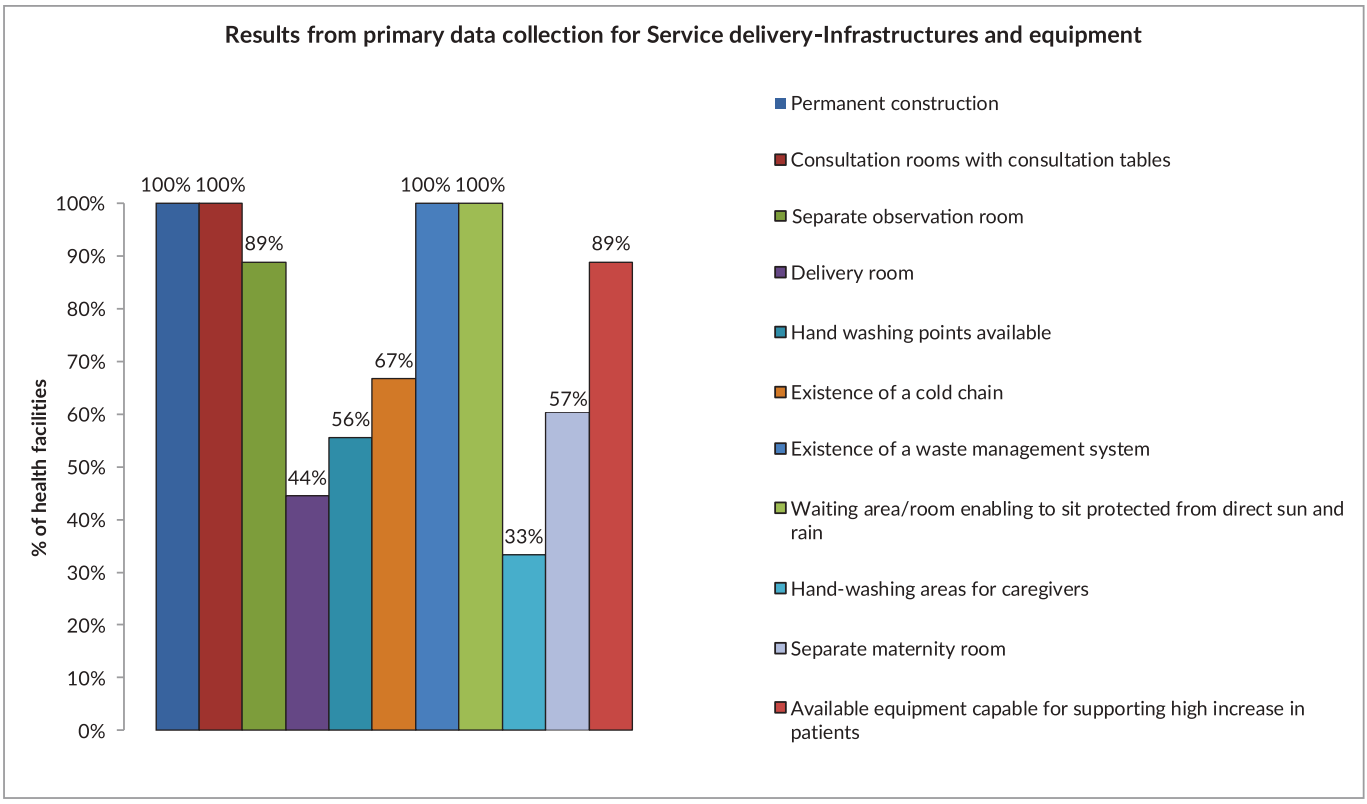
Service delivery		1.55
16	Availability and continuity of care	1.25
17	Coverage and access to RMNCH services	1.25
18	Utilisation	2.00
19	Quality assurance	1.50
20	Community participation in service delivery	1.67

There are only 2 birthing centres available in the *Palika* (Prithvi Chandra hospital and Amarban HP) however, they do not have special services for new born e.g. Sick New Born Care Unit (SNCU). There are also limited Outpatient Therapeutic Care Centres (OTCCs) in the *Palika* to provide treatment to acutely malnourished children. There is an existence of referral system between the different levels of the health care system but no proper follow up is done after referral. The distance between the health facilities and the hospital varies from 30-60 minutes. Referral slip is rarely filled and sent to higher authorities. Communities have access to services with an opening hour in health facilities and on call service available only in the hospital. National Strategy to reach the unreached people published in 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 be create an insufficient utilisation of services.

Basic health care package is free in government entities however, all health 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. This was also evident during COVID-19, when health facilities were reluctant to provide services as well as beneficiaries were not visiting the HFs for the services. There is no periodic supervision from the *Palika* as well as no feedback mechanism on supervision. Basic infrastructures are present in all the health facilities but drinking water station, 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 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 channelised 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 level 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, health facilities report more than 200 indicators via District Health Information Software (DHIS)-2. All the health facilities 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 were DHIS-2 is not in practice, paper-based reporting in done to *Palika* and from *Palika* reports are sent to DHIS-2.

Based on the primary data collection, the annual report is prepared at *Palika* level but no feedback mechanism exists for corrective actions. Health Facilities' 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 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

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.*

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 HIIS. 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: Strength and weakness of HIS building block in *Ramgram*

Strength	Weakness
▪ There is availability of formats for monthly activity reports through HMIS. ▪ Reports sent in a timely manner (according to deadlines set up by the MoHP). ▪ Reports sent electronically (DHIS-2) through the *Palika*. ▪ Prepare annual report at the *Palika* level. ▪ There is specific person in charge of the analysis of health information at the HF and the *Palika* levels.	▪ Unavailability of formats for weekly reports in epidemiological surveillance at the HF level. ▪ There is no good transmission circuit of health information (78% of the HFs reported this). ▪ There is no analysis of HMIS data at the HF level. ▪ HMIS service registers are not filled completely. ▪ HMIS reports are not properly completed (33% of the HFs reported this).

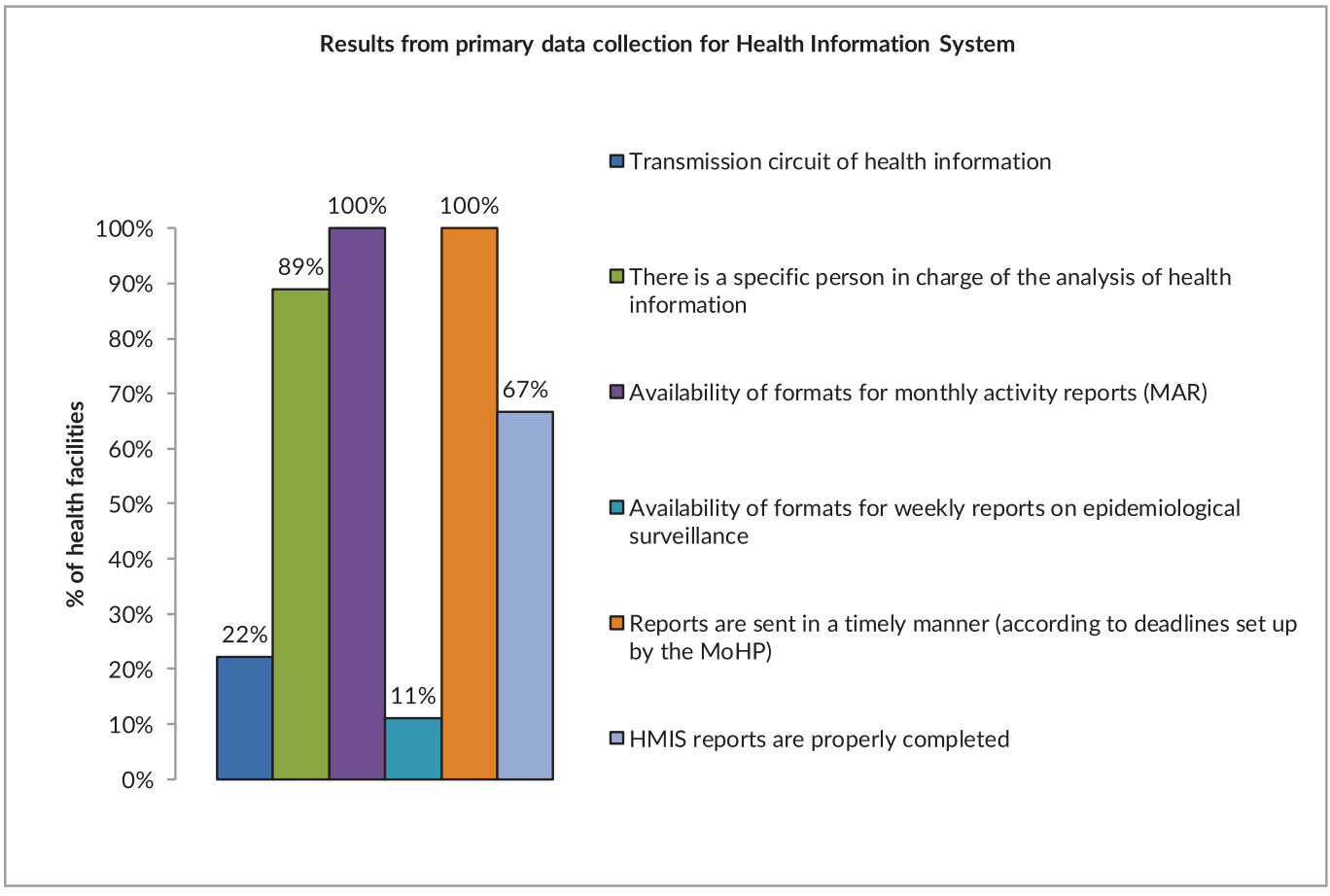
The Health Information System was scored as 'present but not adequate with a score of 1.33 out of 3. This reflects that system are in place for the data collection, monitoring and reporting but not implemented properly. Indeed, no proper analysis and utilisation of the data is performed to improve the programmes, assess the HFs' performance or develop activities to better answer the specific needs of the population.

Table: Results for the Health Information System building block

Health Information System		1.33
21	Integration of RMNCH services in Health Information System	1.56
22	Monitoring and Evaluation	0.67

A national guide on health data collection exists but is not always correctly applied, for instance the services register are incomplete, and the recording is not properly performed. Based on the data collected, it has been observed that HFs were not issuing properly filled report, on top of that it was mentioned that reports were mostly complete, but 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* analyse 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.

17 *Progress of the Health and Population Sector, 2019/20, National Joint Annual Review Report – 2020 (2077 BS), GoN, MoHP, November 2020*



Graph: Summary of results of primary data for HIS

A strong channel for the transmission of health information from grassroots level up to the national/ federal level exists and is used by all levels. It allows reports to be sent as per the deadline set of 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 *Palika*, 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 Health Information System, scored 'adequate.' The two building blocks (financing and HIS) got 'present but not adequate' scoring. When it comes to shock, governance and supply has been categorised as 'highly adequate', whereas HIS has been scored as 'adequate' and financing, HR and service delivery got 'present but not adequate' scoring.

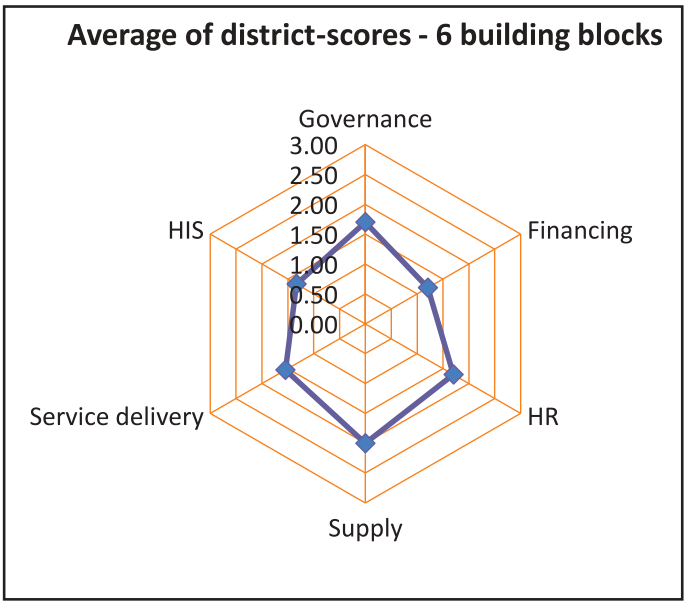


Table: Indicator results for each building block

Average scores for building blocks					
Governance	Financing	HR	Supply	Service delivery	HIS
1.70	1.21	1.70	2.00	1.55	1.33

Table: Indicator results for shock indicators of each building block

Average scores for shock indicators					
Governance	Financing	HR	Supply	Service delivery	HIS
2.33	1.00	1.25	2.33	1.00	2.00

No indicator was scored as "Not adequate at all", which shows that all the minimum requirements of a health system are present in the *Palika*, however; they might not be working correctly. For the four other building blocks, they were scored as 'adequate', and then as 'present but not adequate' for remaining two indicators. These global results suggest that the health system of the *Palika* already has a structure in place for each of the building block, 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	• COVID-19 supported to realise the capacity of the *Palika* to identify and solve problems. • COVID-19 increased coordination and cooperation with various stakeholders at federal, province and local level. • There was maximum mobilisation of skilled human resource with high motivation by the *Palika*. • *Palika's* capacity enhanced to be better prepared for response. • 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.	• It was difficult to take timely decision because COVID-19 is novel. • It was not feasible to conduct regular meeting, 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	• There is establishment of different emergency fund amid COVID-19. • Health has been prioritised in budget allocation. • It provided an opportunity to explore external sources and mobilisation. • There is provision of health insurance for COVID-19.	• It was difficult to conduct health related programmes. • It was difficult to manage health infrastructures and equipment for health due to limited investment in health. • There is limited investment in health due to decrease in income of the *Palika* amid COVID-19.
Human resource	• The *Palika* appointed staffs for the laboratory services. • The government has made provision of 'risk allowance' during COVID-19.	• 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. • It was difficult for service seeker/patient to seek services due to unavailability of transportation during COVID-19. • 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.
Supply	• 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 *Palika* has been able to manage isolation bed and other supplies in existing health structures with available resources.	• 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	• 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 was development of good practices like hand washing among both health workers and patients. • Patients/service seeker are more aware about their health	• Difficulty for service seeker/patient to take services due to unavailability of transportation, especially due to movement restrictions during COVID-19 • Health workers were afraid/ reluctant to provide health services especially services that required physical contact • It was difficult to deliver quality services 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, MUAC assessment, immunisation programme, National Vitamin A campaign, monthly reporting, training, supply of medicines, monthly reporting etc., which is normalising now. • There was decrease in patients seeking health services via health facilities.
Health Information System	• 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.	• There were issues in collection of accurate and verified information. • 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 group work in *Ramgram* Municipality

3.2.9 PRIORITISATION

Now that 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" are 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 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
Reports generated from Health Information System (HIS) are incomplete and of poor quality and the information is not used to take corrective actions	By FY 2079/80, reports generated with the HIS are complete and of good quality and the information is utilised at local level
Mechanism to analyse the health facility's performance does not exist and not implemented	Implement indicator based evaluation system for effective work performance and evaluation of all health facilities within FY 2079/80
Health facilities are not equipped with infrastructure and equipment (medical and non-medical) according to the national norms	By FY 2080/81, all the health facilities will be equipped with essential physical infrastructures and basic equipment according to the national norms
Lack of sufficient, equitable, timely and updated Human Resource at health facilities	Equitable, sufficient and timely update of human resource in all health facilities by FY 2079/80
Essential health services of the continuum of RMNCH services are not continuously available through the various levels of the health system	In 3 years, by FY 2080/81, the essential health services of the continuum of Reproductive, Maternal, Neonatal and Child Health are continuously available through the various levels of the health system

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

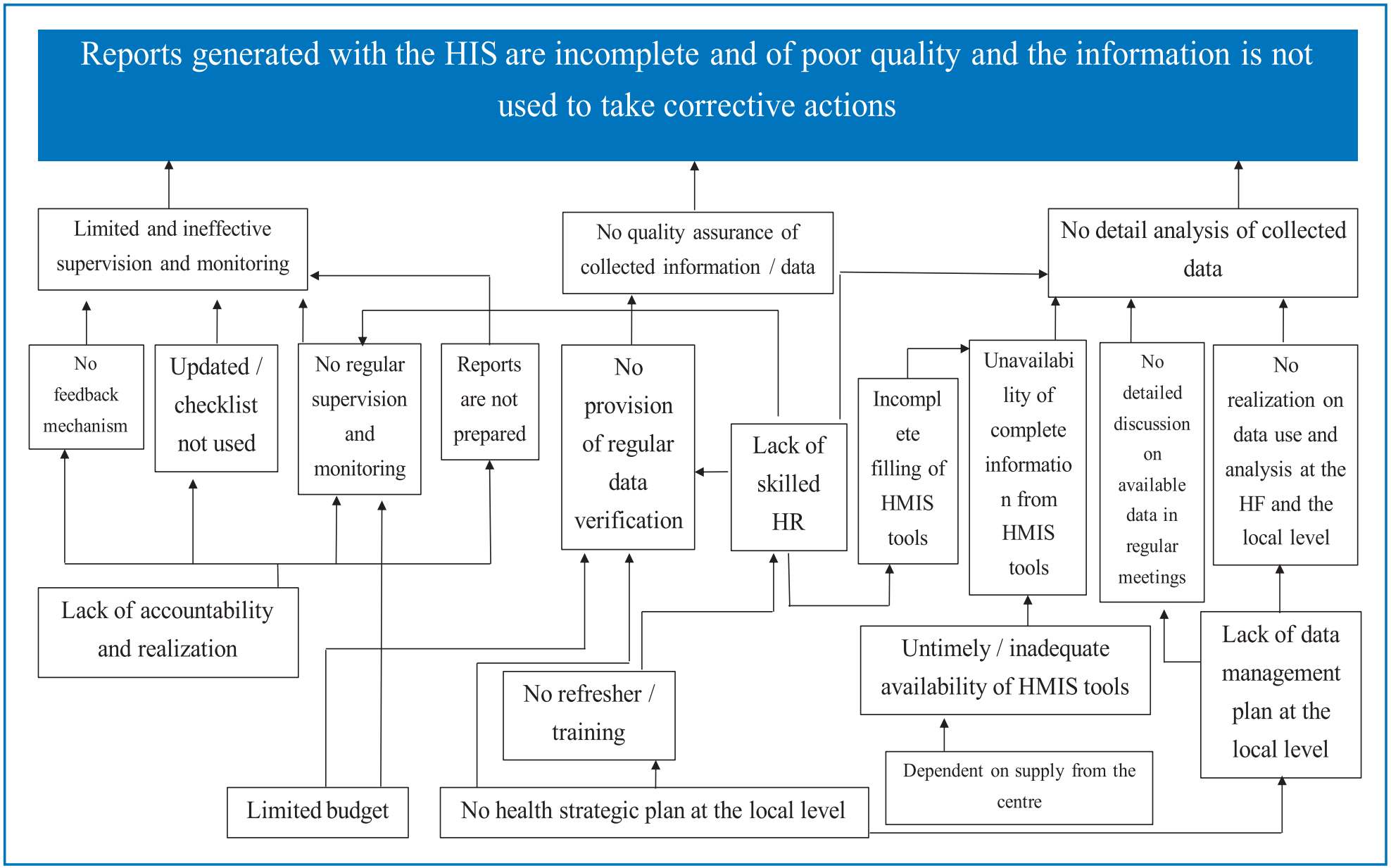


Figure: Causal tree – 1

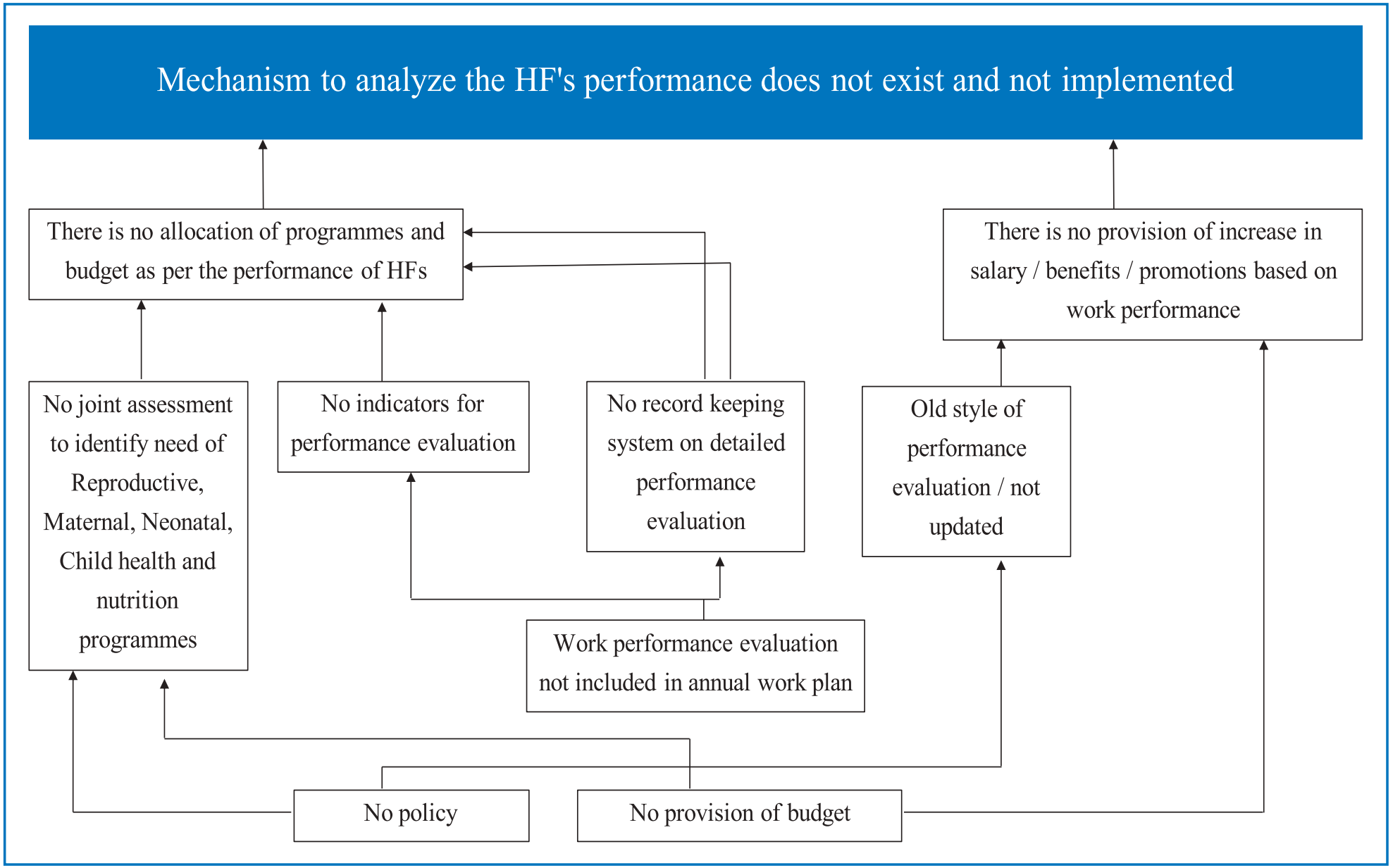


Figure: Causal tree – 2

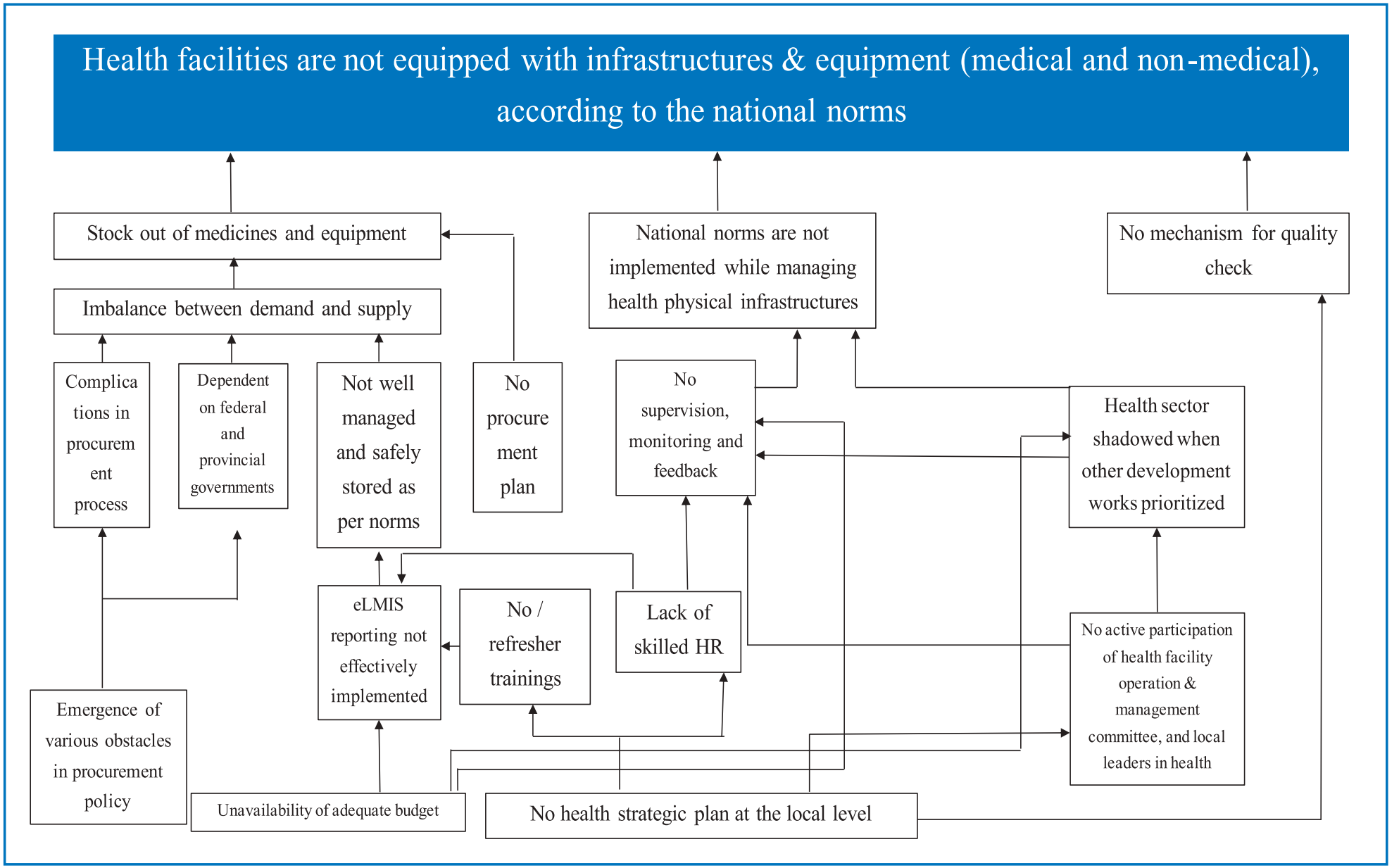


Figure: Causal tree – 3

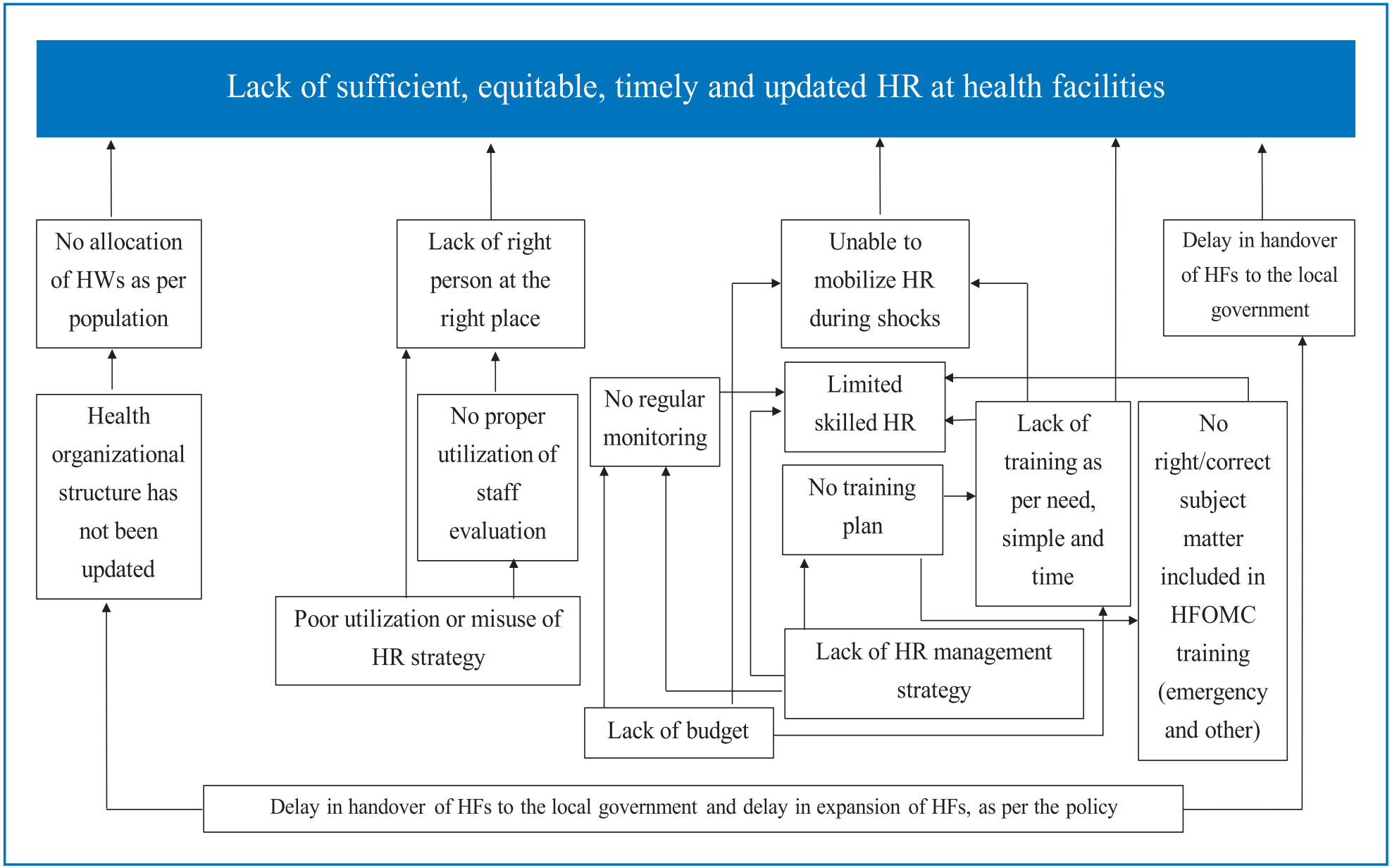


Figure: Causal tree – 4

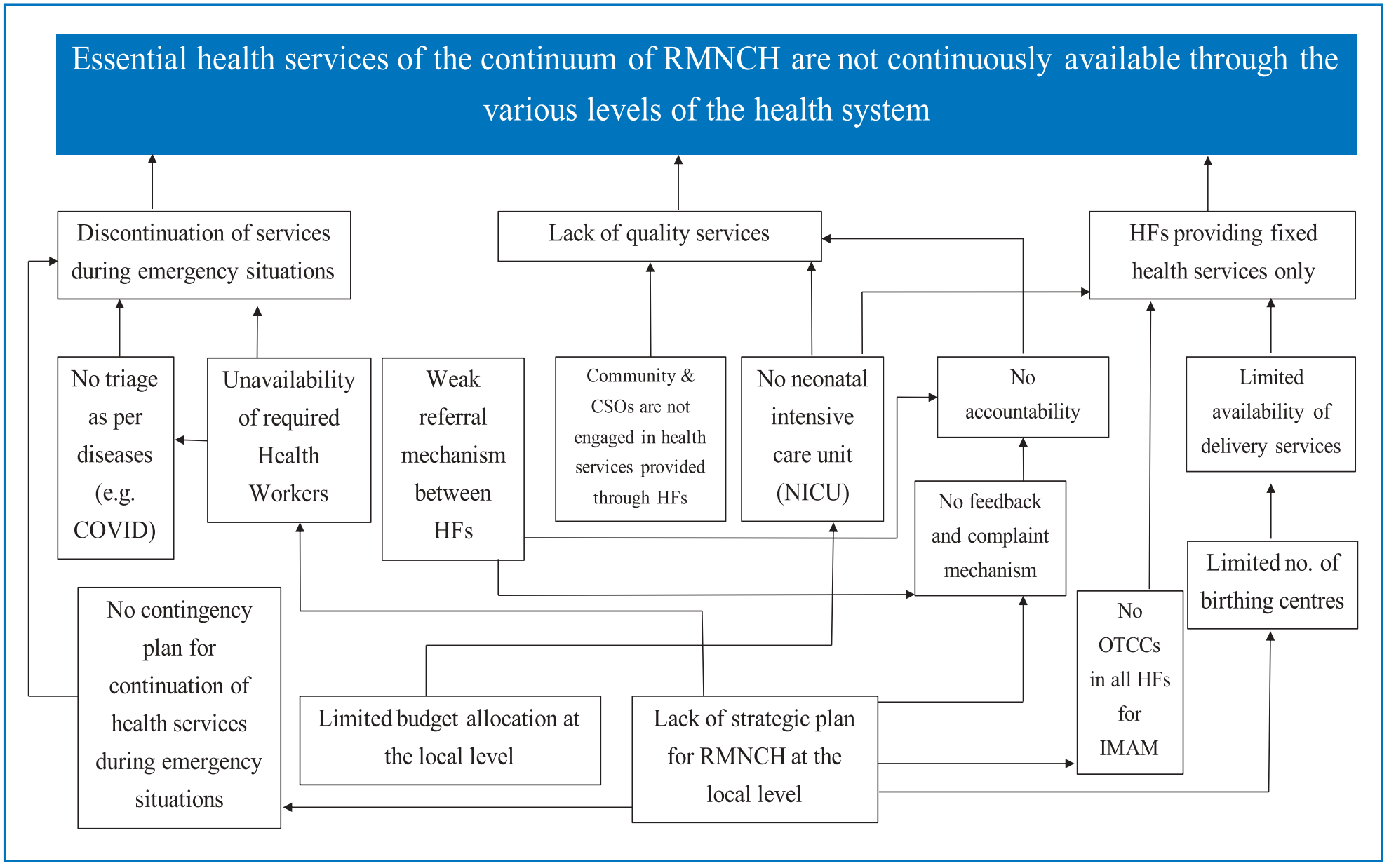


Figure: Causal tree – 5

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.

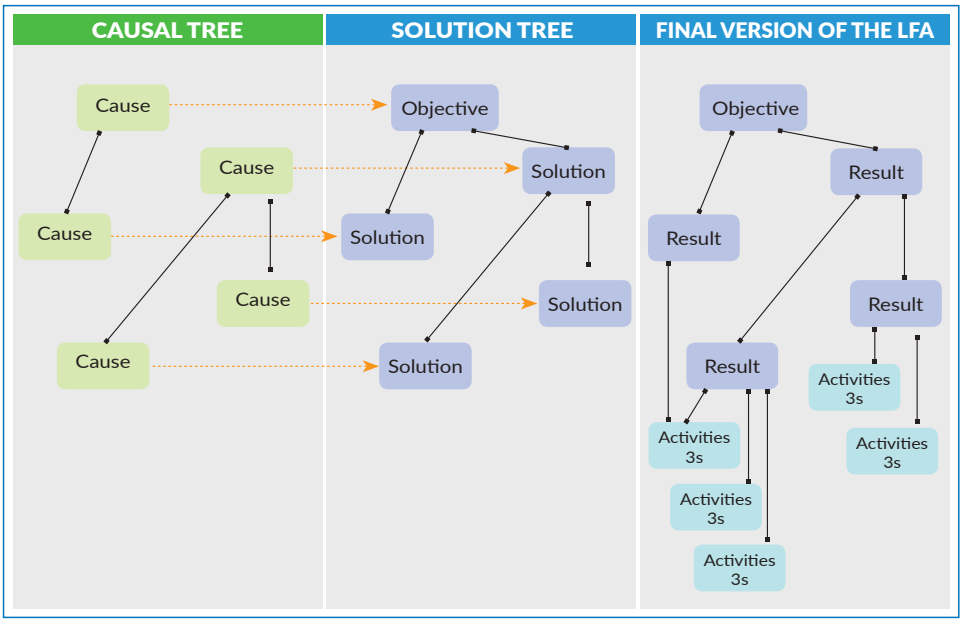


Figure: Theory of change and logical framework

Photo: Planning workshop in Ramgram municipality

These objectives permit to tackle all the prioritised bottlenecks and weaknesses of the health system.

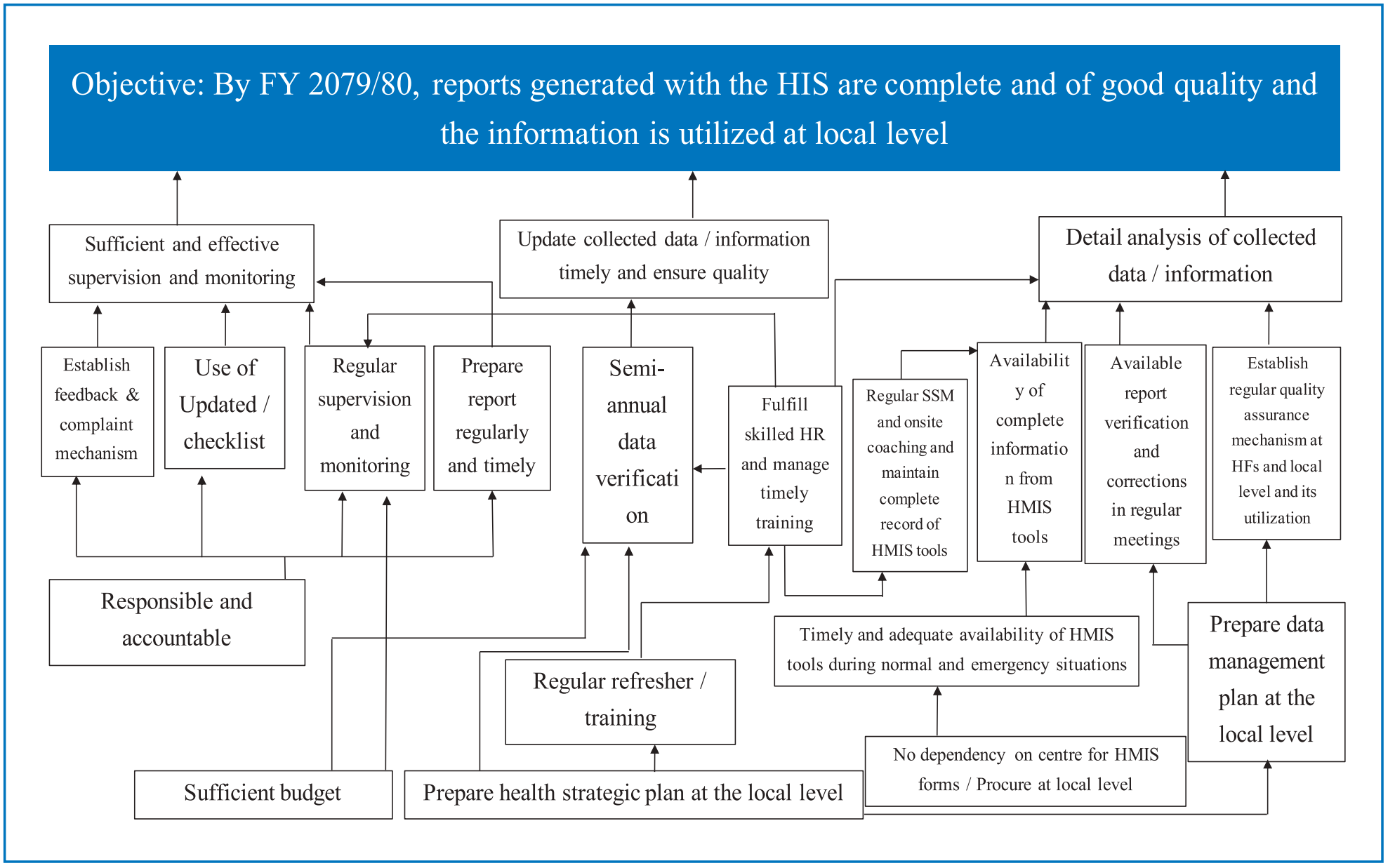


Figure: Solution tree along with HSS objective – 1

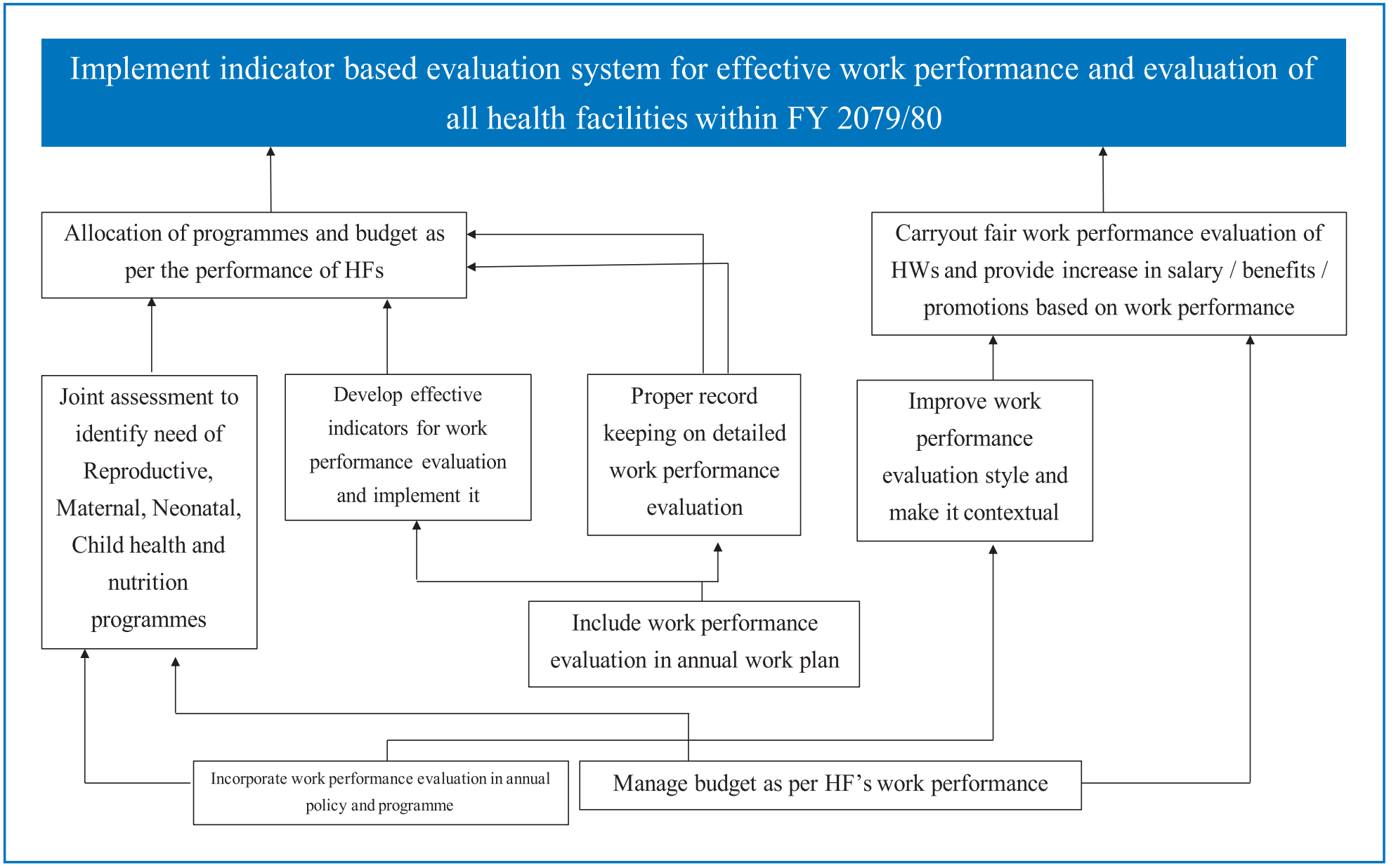


Figure: Solution tree along with HSS objective – 2

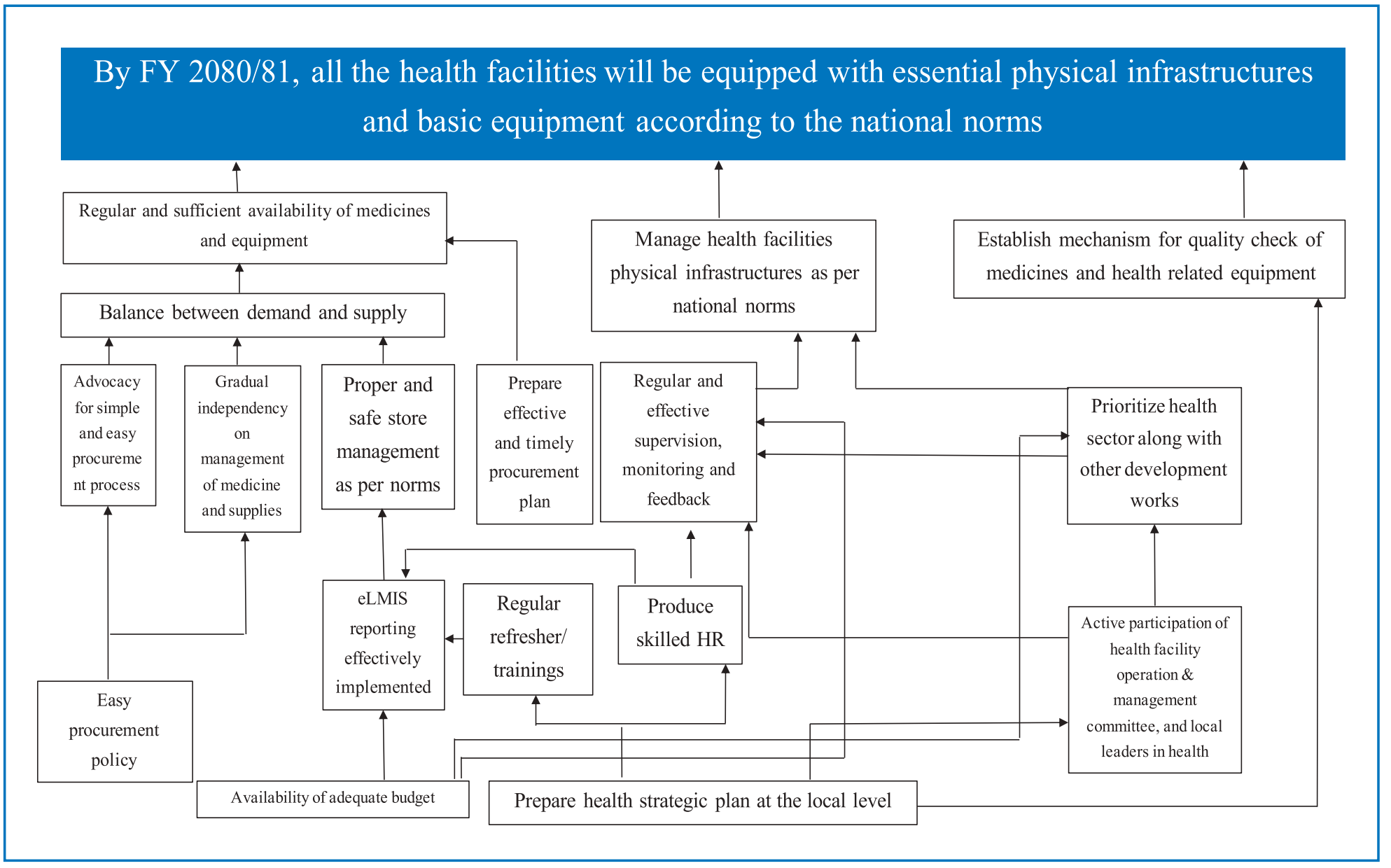


Figure: Solution tree along with HSS objective – 3

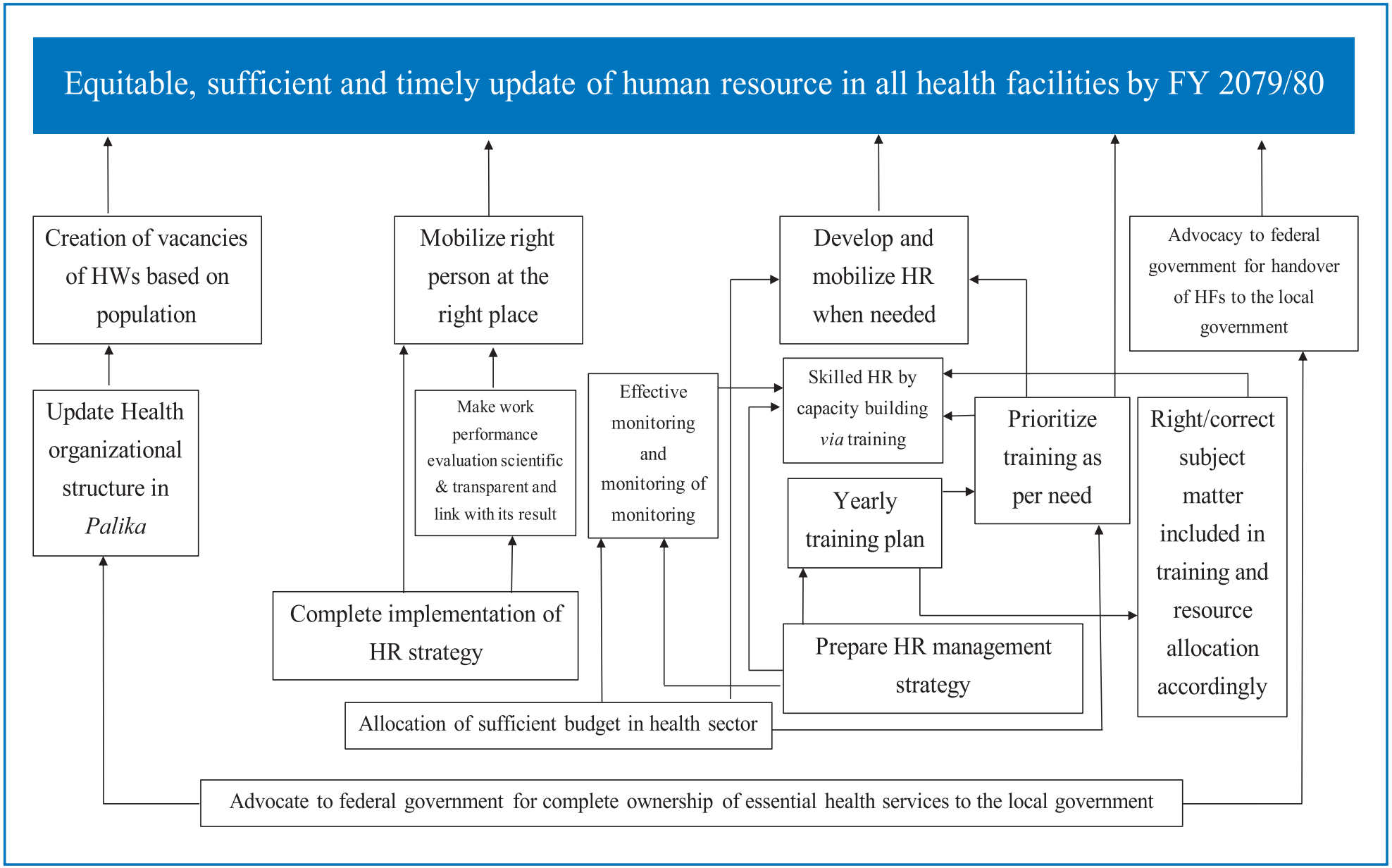


Figure: Solution tree along with HSS objective – 4

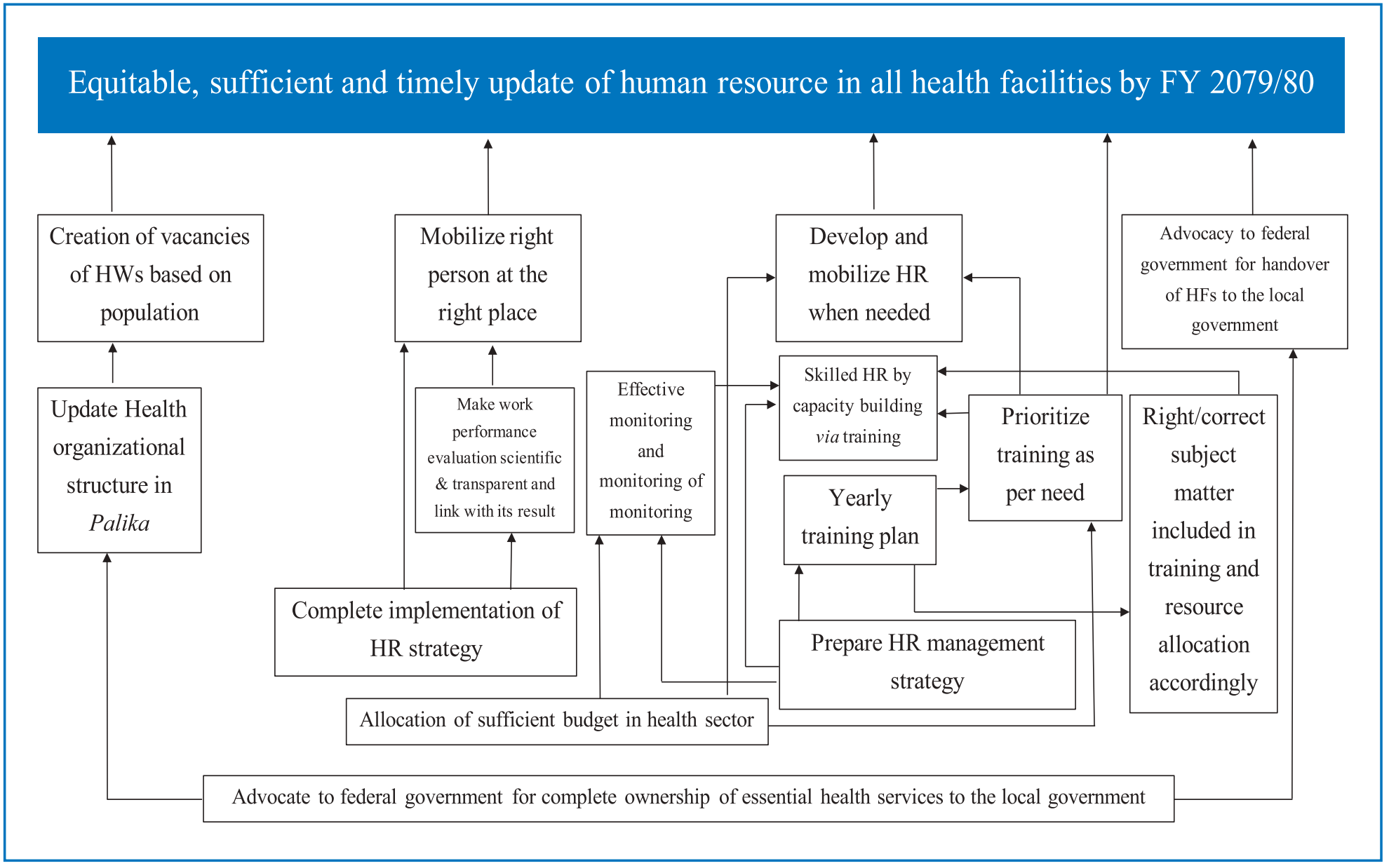


Figure: Solution tree along with HSS objective – 5

These HSS objectives are used as a basis for the development of the action plan, and several results are 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, 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 action plan was developed for the *Palika*, which included strengthening, support and substitution activities, for different phase i.e. normal, alert, serious and emergency for all the HSS objectives.

The developed multi-year action plan for all the 5 HSS objectives were as follows :

	Activities	YEAR 1			YEAR 2			YEAR 3			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
HSS Objective 1 : By FY 2079/80, reports generated with the HIS are complete and of good quality and the information is utilised at local level																		
Result 1: Monitoring and supervision will be done adequately and effectively																		
Strengthening	Install suggestion box in all health facilities	X									X	X	X	X	20,000	Health section, *Ramgram* 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, *Ramgram* municipality		
	Develop necessary forms/formats for recording all collected complaints and feedback via suggestion box		X								X				-	Health section, *Ramgram* municipality		
	Initiate hotline number for the management of collected complaints and feedback		X								X	X	X	X	48,000	Health section, *Ramgram* municipality		
	Appoint a focal person for the management of all collected complaints and feedback via hotline number		X								X				-	Health section, *Ramgram* municipality		

HSS Objective 1 : By FY 2079/80, reports generated with the HIS are complete and of good quality and the information is utilised at local level																		
	Activities	YEAR 1			YEAR 2			YEAR 3			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Strengthening	Develop necessary forms/formats for recording all collected complaints and feedback via hotline number		X								X				-	Health section, *Ramgram* municipality		
	Conduct public hearing of health services/ programmes in yearly basis			X			X				X				100,000	Health section, *Ramgram* municipality	Health Office	
	Conduct joint integrated supportive supervision and monitoring (SSM) and submit report of SSM (For instance, Nutrition and Food Security Steering Committee etc.)	X		X	X		X				X	X	X	X	56,000	Health section, Administration section, *Ramgram* municipality	Health Office, relevant stakeholders and supporting agencies at local level	
	Conduct supportive supervision and monitoring (SSM) regularly of monthly and special programmes and submit report of SSM visit by *Palika*	X	X	X	X	X	X				X	X	X	X	60,000	Health section, Administration section, *Ramgram* municipality	Health Office, supporting agencies	

HSS Objective 1 : By FY 2079/80, reports generated with the HIS are complete and of good quality and the information is utilised at local level																		
	Activities	YEAR 1			YEAR 2			YEAR 3			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Strengthening	Conduct SSM regularly by health facilities of health related programmes and submit report	X	X	X	X	X	X				X	X	X	X	254,800	Health facility	Health section, *Ramgram* municipality	Transportation cost
	Conduct monthly meetings of FCHVs in respective health facilities	X	X	X	X	X	X				X	X			988,800	Health facility	Health section, *Ramgram* municipality	
	Conduct monthly meetings of health workers in respective health facilities	X	X	X	X	X	X				X	X			312,000	Health facility	Health section, *Ramgram* municipality	
	Conduct monthly meeting of health facility-in-charge at *Palika*	X	X	X	X	X	X				X	X			540,000	Health section, *Ramgram* municipality		
Support	Develop integrated checklist for monitoring and supervision of health related programmes and update it as and when necessary			X							X				35,000	Health section, *Ramgram* municipality	Health Office, supporting agencies	
	Conduct SSM regularly in coordination with relevant stakeholders and supporting agencies and submit report	X	X	X	X	X	X				X	X			60,000	Health section, *Ramgram* municipality	Health Office, supporting agencies	

HSS Objective 1 : By FY 2079/80, reports generated with the HIS are complete and of good quality and the information is utilised at local level																		
	Activities	YEAR 1			YEAR 2			YEAR 3			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Substitution	Conduct SSM by supporting agencies during emergency situations												X	X	As per need	Supporting agencies	Health section, *Ramgram* municipality; Health Office	
	Develop a system and manage HR for vertical recording and reporting during emergency situations												X	X	As per need	Supporting agencies	Health section, *Ramgram* municipality; Health Office	
Result 2: All the collected data and information will be of good quality and updated in a timely manner																		
Strengthening	Conduct semi-annual Routine Data Quality Assurance (RDQA) in all health facilities		X	X		X	X				X				288,000	Health section, *Ramgram* municipality	Health facility	Routine Data Quality Assurance
	Conduct yearly RDQA at municipal level	X			X						X				75,900	Health section, *Ramgram* municipality	Health facility	Routine Data Quality Assurance
	Incorporate Health Management Information System (HMIS) related refresher/training in training plan developed at local level	X			X						X	X			-	Health section, *Ramgram* municipality	Supporting agencies	

HSS Objective 1 : By FY 2079/80, reports generated with the HIS are complete and of good quality and the information is utilised at local level																		
	Activities	YEAR 1			YEAR 2			YEAR 3			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Support	Conduct annual review at municipal level	X			X						X				151,800	Health section, *Ramgram* municipality	Supporting agencies	
	Conduct 3 days one batch of basic HMIS training for health workers		X			X					X				172,700	Health section, *Ramgram* municipality	Health Office, supporting agencies	
	Conduct 2 days one batch of HMIS refresher training for health workers		X			X					X				121,300	Health section, *Ramgram* municipality	Health Office, supporting agencies	
	Conduct 4 days two batch of basic DHIS-2 training for health workers	X			X						X				568,400	Health section, *Ramgram* municipality	Health Office, supporting agencies	
	Conduct 2 days eight batch of HMIS refresher training for FCHVs		X			X					X				279,500	Health section, *Ramgram* municipality	Health Office, supporting agencies	
	Conduct one day orientation on RDQA in all health facilities	X			X						X	X			139,800	Health section, *Ramgram* municipality	Health Office, supporting agencies	
Substitution	Semi-annual data verification of vertical recording and reporting during emergency situations												X	X	As per need	Supporting agencies	Health section, *Ramgram* municipality; Health Office	

HSS Objective 1 : By FY 2079/80, reports generated with the HIS are complete and of good quality and the information is utilised at local level																		
	Activities	YEAR 1			YEAR 2			YEAR 3			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Result 3: Detailed analysis of all the collected data and information will be done																		
Strengthening	Print and distribute HMIS forms and formats in a yearly basis by *Palika*	X			X						X	X			540,000	Health section, *Ramgram* municipality	Health Office, supporting agencies	
	Carry out detailed analysis of collected data and information obtained from RDQA semi annually		X	X		X	X				X				132,000	Health section, *Ramgram* municipality	Health Office	
	Carry out detailed analysis of collected data and information from HMIS for the preparation of annual report	X			X						X	X	X	X	-	Health section, *Ramgram* municipality	Health Office, supporting agencies	
	Incorporate Health Management Information System (HMIS) while preparing health's strategic plan	X			X						X	X	X	X	-	Health section, *Ramgram* municipality	Health Office, supporting agencies	
Support	Develop and update health profile in a yearly basis	X			X						X	X			85,000	Health section, *Ramgram* municipality	Health Office, supporting agencies	

HSS Objective 1 : By FY 2079/80, reports generated with the HIS are complete and of good quality and the information is utilised at local level																		
	Activities	YEAR 1			YEAR 2			YEAR 3			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Substitution	Timely availability of sufficient HMIS forms and formats by supporting agencies during emergency situations												X	X	As per need	Supporting agencies	Health section, *Ramgram* municipality; Health Office	

HSS Objective 2: Implement indicator based evaluation system for effective work performance and evaluation of all health facilities within FY 2079/80																		
	Activities	YEAR 1			YEAR 2			YEAR 3			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Result 1: Programme designing and allocation of budget will be done based on the work performance and evaluation of health facilities																		
Strengthening	Update key indicators of work performance evaluation for health facilities	X									X				-	Health section, *Ramgram* municipality	Health Office; supporting agencies	
	Prepare criteria and implementation plan for work performance evaluation grading	X									X				-	Health section, *Ramgram* municipality	Health Office; supporting agencies	
	Form work performance evaluation committee/unit for work performance evaluation of health facilities at *Palika* level	X									X				-	Health section, *Ramgram* municipality		
	Incorporate work performance evaluation in annual work plan	X									X				-	Health section, *Ramgram* municipality		
	Define yearly target for each health facility based on indicators of work performance evaluation	X			X						X				-	Health facility	Health section, *Ramgram* municipality	

HSS Objective 2: Implement indicator based evaluation system for effective work performance and evaluation of all health facilities within FY 2079/80																		
	Activities	YEAR 1			YEAR 2			YEAR 3			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Strengthening	Conduct work performance evaluation based on set target of health facilities			X			X				X				-	Health section, *Ramgram* municipality		
	Grade all health facilities based on observation and discussion in health facilities by work performance evaluation committee or responsible officer			X			X				X				-	Health section, *Ramgram* municipality		
	Manage provision of reward and punishment system based on grading of health facilities			X			X				X				100,000	Health section, *Ramgram* municipality		
Support	Discuss and orient about indicators to health facilities and *Palika*				X						X				100,000	Health section, *Ramgram* municipality	Health Office; supporting agencies	

HSS Objective 2: Implement indicator based evaluation system for effective work performance and evaluation of all health facilities within FY 2079/80																		
	Activities	YEAR 1			YEAR 2			YEAR 3			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Support	Inform about work performance evaluation indicators and criteria to all health workers by respective health facility-in-charge during regular meetings				X						X				-	Health facility	Health section, *Ramgram* municipality; supporting agencies	
	Inform Health facility Operation and Management Committee (HFOMC) members about work performance evaluation during regular meetings				X						X				-	Health section, *Ramgram* municipality	Supporting agencies	
	Capacity building of work performance evaluation committee and health facility in-charge by recommending for training or field visit in relevant section or department		X								X				100,000	Health section, *Ramgram* municipality	Supporting agencies	

HSS Objective 2: Implement indicator based evaluation system for effective work performance and evaluation of all health facilities within FY 2079/80																	
	Activities	YEAR 1			YEAR 2			YEAR 3			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Support	Basic assessment to know the situation of Reproductive, maternal, neonatal & child health (RMNCH) and nutrition	X									X	X			250,000	Health section, *Ramgram* municipality	Supporting agencies	
Result 2: Benefits and promotion will be provided based on work performance evaluation of health workers																		
Strengthening	Form a committee to review and update as necessary the existing health workers work performance evaluation forms and working modality		X								X				-	Health section, *Ramgram* 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	X			-	Health section, *Ramgram* municipality		

HSS Objective 2: Implement indicator based evaluation system for effective work performance and evaluation of all health facilities within FY 2079/80																		
	Activities	YEAR 1			YEAR 2			YEAR 3			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Strengthening	Provide a copy of work performance evaluation to each health workers after completion of work performance evaluation			X			X				X	X			-	Health section, *Ramgram* municipality		
	Ensure transparency of work performance evaluation			X			X				X	X			-	Health section, *Ramgram* municipality		
Support	Manage provision of reward and punishment to health workers based on work performance evaluation			X			X				X	X			500,000	Health section, *Ramgram* municipality	Supporting agencies	
	Field exchange visit for observing health facilities with good work performance evaluation by health facilities with low or less work performance evaluation			X			X				X	X			50,000	Health section, *Ramgram* municipality	Supporting agencies	

HSS Objective 3: By FY 2080/81, all the health facilities will be equipped with essential physical infrastructures and basic equipment according to the national norms																		
	Activities	YEAR 1			YEAR 2			YEAR 3			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 medicine and health supplies will be regular and sufficient																		
Strengthening	Project requirements of medicine and equipment for procurement	X		X	X		X	X		X	X	X	X	X	-	Health section, *Ramgram* municipality	Health Office	
	Manage separate storage in *Palika* for medicine and supplies			X							X	X			-	Health section, *Ramgram* municipality		
	Advocate to Provincial and Federal level for timely availability of medicine and supplies	X			X			X			X	X			-	Health section, *Ramgram* municipality	Health Office	
	Classify all medicines and supplies available via local and province/ federal level	X		X	X		X	X		X	X	X			-	Health section, *Ramgram* municipality	Health Office	
	Advocate for simple and easy procurement policy and process		X		X		X				X	X	X	X	-	Health section, *Ramgram* municipality	Health Office	
	Establish a cold chain within *Palika*			X							X	X	X	X	1,000,000	Health section, *Ramgram* municipality	Health Office; supporting agencies	
	Manage equipment and supplies required for storage like rack, pallet, fire extinguisher, thermometer etc.			X			X			X	X	X	X	X	500,000	Health section, *Ramgram* municipality	Health Office; supporting agencies	

HSS Objective 3: By FY 2080/81, all the health facilities will be equipped with essential physical infrastructures and basic equipment according to the national norms																		
	Activities	YEAR 1			YEAR 2			YEAR 3			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Strengthening	Transport medicine and health related supplies following a pre-defined plan/ schedule	X	X	X	X	X	X	X	X	X	X	X	X	X	100,000	Health section, *Ramgram* municipality	Health Office; supporting agencies	
	Discuss with all health facility in-charge within *Palika* prior for preparation of procurement plan	X			X			X			X	X			90,000	Health section, *Ramgram* municipality	Health Office; supporting agencies	
	Gradual increase of budget allocation in health by *Palika*			X			X			X	X	X	X	X	-	Health section, *Ramgram* municipality	Health Office	
	Manage and update all records of health workers within *Palika* who have received training on management of medicine and health supplies	X	X	X	X	X	X	X	X	X	X	X	X	X	-	Health section, *Ramgram* municipality		
	Manage necessary equipment and training to make all health facilities technology friendly		X			X			X		X	X	X	X	1,200,000	Health section, *Ramgram* municipality	Health Office; supporting agencies	

HSS Objective 3: By FY 2080/81, all the health facilities will be equipped with essential physical infrastructures and basic equipment according to the national norms																		
	Activities	YEAR 1			YEAR 2			YEAR 3			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Strengthening	Conduct meeting for regular discussion, review and feedback on LMIS reporting	X	X	X	X	X	X	X	X	X	X	X	X		150,000	Health section, *Ramgram* municipality	Health Office; supporting agencies	
	Advocate for timely release of fund from province and federal level	X			X			X			X	X	X	X	-	Health section, *Ramgram* municipality	Health Office	
	Manage Adequate Stock Level (ASL) and Emergency Order Point (EOP) of essential medicines and use of bin/stock card in health facilities	X	X	X	X	X	X	X	X	X	X	X	X	X	-	Health section, *Ramgram* municipality	Health Office	
Support	Operate eLMIS in *Palika*				X						X	X	X		-	Health section, *Ramgram* municipality	Health Office; supporting agencies	
	Conduct training/ refresher on eLMIS				X			X			X	X			100,000	Health section, *Ramgram* municipality	Health Office; supporting agencies	
	Conduct training/ refresher on procurement and quantification of medicines and supplies	X			X			X			X	X	X	X	200,000	Health section, *Ramgram* municipality	Health Office; supporting agencies	

HSS Objective 3: By FY 2080/81, all the health facilities will be equipped with essential physical infrastructures and basic equipment according to the national norms																		
	Activities	YEAR 1			YEAR 2			YEAR 3			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Support	Conduct training/ refresher to health workers on proper management of storage of medicines and health supplies	X			X			X							150,000	Health section, *Ramgram* municipality	Health Office; supporting agencies	
Substitution	Appoint a separate pharmacist for management of medicines and health supplies storage												X	X	As per need	Supporting agencies	Health section, *Ramgram* municipality; Health Office	
	Manage properly medicines and health supplies procurement, separate storage and transportation												X	X	As per need	Supporting agencies	Health section, *Ramgram* municipality; Health Office	
Result 2: Basic infrastructure of health facilities will be managed according to national standards/norms																		
Strengthening	Prepare a schedule for monitoring physical infrastructures of health facilities	X	X	X	X	X	X	X	X	X	X	X			-	Health Facility Operation and Management Committee; Health section, *Ramgram* municipality		

HSS Objective 3: By FY 2080/81, all the health facilities will be equipped with essential physical infrastructures and basic equipment according to the national norms																		
	Activities	YEAR 1			YEAR 2			YEAR 3			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Strengthening	Use of checklist during monitoring and supervision and submission of report	X	X	X	X	X	X	X	X	X	X	X	X	X	-	Health Facility Operation and Management Committee; Health section, *Ramgram* municipality		Jointly monitoring and supervision
	Gradual increase in budget allocation for the development of health infrastructure										X	X			As per need	Health section, *Ramgram* municipality		
	Advocate to increase budget at province and federal level for development of health infrastructures										X	X			-	Health section, *Ramgram* municipality	Health Office	
	Advocate for timely release of fund from province and federal level for development of health infrastructures	X	X	X	X	X	X	X	X	X	X	X			-	Health section, *Ramgram* municipality	Health Office	
Support	Conduct orientation on health related rules & regulations, criteria, protocol and guideline to Health Facility Operation and Management Committee (HFOMC)			X			X			X	X	X			270,000	Health section, *Ramgram* municipality	Health Office; supporting agencies	

HSS Objective 3: By FY 2080/81, all the health facilities will be equipped with essential physical infrastructures and basic equipment according to the national norms																		
	Activities	YEAR 1			YEAR 2			YEAR 3			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Substitution	Manage health infrastructures during emergency situations												X	X	As per need	Supporting agencies	Health section, *Ramgram* municipality; Health Office	
Result 3: A system will be established for measuring quality of medicines and health related equipment																		
Strengthening	Coordinate at federal level for quality check of medicines and health supplies procured at local level	X	X	X	X	X	X	X	X	X	X	X	X	X	-	Health section, *Ramgram* municipality	Health Office; supporting agencies	
	Include quality check of medicines and health supplies in health strategic plan		X	X											-	Health section, *Ramgram* municipality	Health Office; supporting agencies	

HSS Objective 4: Equitable, sufficient and timely update of human resource in all health facilities by FY 2079/80																		
	Activities	YEAR 1			YEAR 2			YEAR 3			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Result 1: Number of health workers position will be allocated based on population																		
Strengthening	Form a committee in leadership of Mayor of municipality and relevant stakeholders (ward chair, health facility in charge etc.) for conducting Organisation and Management (O &M) survey	X									X				-	*Ramgram* municipality		
	Conduct 2 batch of 1 day each workshop for O&M survey		X	X							X				300,000	*Ramgram* municipality		
	Select expert individual/group for conducting O&M survey			X							X				100,000	*Ramgram* municipality		
	Conduct O&M survey and endorse the report of O&M survey from municipal council			X							X				-	*Ramgram* municipality		
	Advocate at federal level for approval of additional position	X									X				-	*Ramgram* municipality		

HSS Objective 4: Equitable, sufficient and timely update of human resource in all health facilities by FY 2079/80																		
	Activities	YEAR 1			YEAR 2			YEAR 3			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Support	Recruit contractual staff for service delivery	X	X	X	X	X	X						X	X	1,000,000	*Ramgram* municipality	Supporting agencies	
Substitution	Manage staff for continuation of essential health related services during emergency by supporting agencies														As per need	Supporting agencies	*Ramgram* municipality	
Result 2: Right person in right place will be appointed																		
Strengthening	Sanction allocated position in interest and capacity of staff based on work performance evaluation	X	X	X	X	X	X				X	X			-	*Ramgram* municipality		
	Form a group/expert to prepare Human Resource (HR) strategy/plan related to health at local level for the implementation of HR policy			X	X						X				-	*Ramgram* municipality	Supporting agencies	

HSS Objective 4: Equitable, sufficient and timely update of human resource in all health facilities by FY 2079/80																		
	Activities	YEAR 1			YEAR 2			YEAR 3			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Strengthening	Conduct 1 day workshop for preparation of HR strategy/plan related to health at local level			X							X				100,000	*Ramgram* municipality	Supporting agencies	
	Prepare HR strategy/ plan related to health at local level			X							X				100,000	*Ramgram* municipality	Supporting agencies	
Result 3: HR will be developed and mobilised as per need																		
Strengthening	Conduct 1 day workshop for preparation of training plan related to health to be incorporated in HR strategy related to health at local level	X									X	X			50,000	Health section, *Ramgram* municipality	Supporting agencies	
	Prepare health related training plan related to health at local level		X								X	X			-	Health section, *Ramgram* municipality	Supporting agencies	
	Identify training requirements in health (individual and subject matter) semi-annually		X	X		X	X				X	X			-	Health section, *Ramgram* municipality	Supporting agencies	

HSS Objective 4: Equitable, sufficient and timely update of human resource in all health facilities by FY 2079/80																	
	Activities	YEAR 1			YEAR 2			YEAR 3			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Strengthening	Prepare training package/guideline incorporating appropriate content in simple language for Health Facility Operation and Management Committee (HFOMC)			X							X	X			50,000	Health section, *Ramgram* municipality	Supporting agencies	
	Prepare/update roster after every training	X	X	X	X	X	X				X	X			-	Health section, *Ramgram* municipality		
	Conduct 2 days training for HFOMC members				X	X					X				120,000	Health section, *Ramgram* municipality	Supporting agencies	
	Provide basic in-service training to newly appointed staff	X			X						X				100,000	Health section, *Ramgram* municipality		
	Overall supportive supervision and monitoring by Social Development Committee of the *Palika*	X	X	X	X	X	X				X	X			30,000	*Ramgram* municipality		

HSS Objective 4: Equitable, sufficient and timely update of human resource in all health facilities by FY 2079/80																		
	Activities	YEAR 1			YEAR 2			YEAR 3			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Strengthening	Use software to document and update profile of all health workers of *Palika*						X				X				500,000	*Ramgram* municipality		
Support	Conduct 4 days training for service delivery during emergency situation including simulation exercise		X			X							X	X	400,000	*Ramgram* municipality		
	Conduct specialised service delivery training utilising internal resources, when necessary												X	X	100,000	Health section, *Ramgram* municipality	Supporting agencies	As per need
Substitution	Obtain support of technical experts from Province and federal level												X	X	As per need	*Ramgram* municipality	Supporting agencies	

HSS Objective 4: Equitable, sufficient and timely update of human resource in all health facilities by FY 2079/80																	
	Activities	YEAR 1			YEAR 2			YEAR 3			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Result 4: Advocacy with federal government will be done for localisation of health facilities																		
Strengthening	Advocate for complete ownership of health facilities via Municipality Association of Nepal (MuAN)	X	X	X							X	X			-	*Ramgram* municipality		
Strengthening	Formulate law for Health Human Resource management policy, standards, services, planning, implementation and regulation	X	X								X				100,000	*Ramgram* municipality		
Support	Obtain advisory services from lawmakers to formulate laws	X	X								X	X			50,000	*Ramgram* municipality	Supporting agencies	

HSS Objective 5: In 3 years, by FY 2080/81, 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	YEAR 1			YEAR 2			YEAR 3			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	Conduct 1 day workshop to prepare contingency plan for continuation of RMNCH services during emergency situations	X	X								X	X	X	X	50,000	Health section, *Ramgram* municipality	Health Office; District Administration Office; District Coordination Committee, Federation of Nepalese Chambers of Commerce and Industry (FNCCI), Red Cross, supporting agencies	
	Form Technical Working Groups to prepare contingency plan for continuation of RMNCH services during emergency situations	X	X								X	X			-	Health section, *Ramgram* municipality	Health Office; District Administration Office; District Coordination Committee, Federation of Nepalese Chambers of Commerce and Industry (FNCCI), Red Cross, supporting agencies	

HSS Objective 5: In 3 years, by FY 2080/81, 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	YEAR 1			YEAR 2			YEAR 3			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Strengthening	Draft contingency plan after incorporating suggestions/discussion from the contingency planning workshop for continuation of RMNCH services during emergency situations by TWG	X	X								X	X			-	Health section, *Ramgram* municipality	Health Office; District Administration Office; District Coordination Committee, Federation of Nepalese Chambers of Commerce and Industry (FNCCI), Red Cross, supporting agencies	
	Endorse contingency plan of *Palika* to continue RMNCH services during emergency situations through municipal office meetings		X	X							X	X			-	*Ramgram* municipality	Health Office; District Administration Office; District Coordination Committee, Federation of Nepalese Chambers of Commerce and Industry (FNCCI), Red Cross, supporting agencies	

HSS Objective 5: In 3 years, by FY 2080/81, 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	YEAR 1			YEAR 2			YEAR 3			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Strengthening	Endorse contingency plan of each health facilities to continue RMNCH services during emergency situations through HFOMC meetings		X	X							X	X			-	Respective health facilities	Health section, *Ramgram* municipality	
	Conduct 2 days' workshop to prepare strategic plan on RMNCH services at the local level	X	X								X	X			120,000	Health section, *Ramgram* municipality	Health Office; supporting agencies	
	Form Technical Working Groups and Advisory Committee to prepare strategic plan on RMNCH services at the local level	X									X	X			-	Health section, *Ramgram* municipality	Health Office; supporting agencies	
	Prepare final draft of the strategic plan after collection of suggestions and feedback from different stakeholders			X							X	X			-	Health section, *Ramgram* municipality	Health Office; supporting agencies	

HSS Objective 5: In 3 years, by FY 2080/81, 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	YEAR 1			YEAR 2			YEAR 3			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 Municipality Council			X							X	X			-	*Ramgram* municipality		
	Conduct 1 day orientation programme on presenting strategic plan to representatives of all health facilities			X							X	X			50,000	Health section, *Ramgram* municipality	Health Office; supporting agencies	
Support	Conduct triage assessment of all health facilities and hospital to collect information on the situation and physical infrastructures	X									X	X	X	X	50,000	Health section, *Ramgram* municipality	Health Office; supporting agencies	
	Procure materials for triage implementation based on the assessment result	X	X								X	X	X	X	95,000	Health section, *Ramgram* municipality	Supporting agencies	
	Develop IEC materials for triage		X								X	X	X	X	28,500	Health section, *Ramgram* municipality	Supporting agencies	

HSS Objective 5: In 3 years, by FY 2080/81, 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	YEAR 1			YEAR 2			YEAR 3			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Support	Conduct 1 day orientation on triage to all health workers of all health facilities and hospital		X								X	X	X	X	57,400	Health section, *Ramgram* municipality	Supporting agencies	
Substitution	Mobilise human resource as per HR roster for the continuation of RMNCH services during emergency												X	X	As per need	*Ramgram* municipality	Provincial and federal government; supporting agencies	
Result 2: Quality services will be available from all the health facilities																		
Strengthening	Make mandatory use of the referral slip by all the health facilities and hospital in order to improve referral mechanism	X	X	X	X	X	X	X	X	X	X	X	X	X	136,800	*Ramgram* municipality	Health Facility, hospital	
	Conduct discussion around referral mechanism in each monthly and semi-annual meetings	X	X	X	X	X	X	X	X	X	X	X			-	*Ramgram* municipality; Health facility; hospital		

HSS Objective 5: In 3 years, by FY 2080/81, 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	YEAR 1			YEAR 2			YEAR 3			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Strengthening	Organise discussion/ make understand about services provided by the health facilities/extended services, feedback and complain regarding quality of services and easiness in monthly health mothers' group meetings (MGMs) and submit report by FCHVs	X	X	X	X	X	X	X	X	X	X	X			-	Health facility	*Ramgram* municipality	
	Organise discussion on service expansion and service continuation in regular HFOMC meetings	X	X	X	X	X	X	X	X	X	X	X			864,000	Health facility	*Ramgram* municipality	
	Invite civil society network (local youth club, child network, different stakeholders) for interactions in HFOMC meetings	X	X	X	X	X	X	X	X	X	X	X			-	Health facility	*Ramgram* municipality	

HSS Objective 5: In 3 years, by FY 2080/81, 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	YEAR 1			YEAR 2			YEAR 3			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Substitution	Conduct public audit of continued RMNCH services during emergencies by supporting agencies														As per need	Supporting agencies	*Ramgram* municipality	
Result 3: All health facilities will be providing all RMNCH services																		
Strengthening	Conduct regular (trimester) supportive supervision and monitoring if service delivery are as per national standards	X	X	X	X	X	X	X	X	X	X	X	X	X	-	*Ramgram* municipality	Supporting agencies	Jointly with other monitoring and supervision visit
Support	Manage a separate room to establish SNCU in the hospital		X								X				2,000,000	Hospital Development Board	Provincial government; Supporting agencies	
	Request to Provincial Ministry of Social Development for material and equipment to establish SNCU in the hospital after preparing list of necessary materials and equipment		X								X				-	Hospital Development Board	Provincial government; Supporting agencies	

HSS Objective 5: In 3 years, by FY 2080/81, 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	YEAR 1			YEAR 2			YEAR 3			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Support	Manage a separate room and equipment (radiant warmer, pulse oximeter) for New-born and Child Health in all health facilities				X	X					X	X			280,000	Health facility; Health section, *Ramgram* municipality	Supporting agencies	
	Manage a separate room for breastfeeding in all health facilities				X	X					X	X	X	X	80,000	Health facility; Health section, *Ramgram* municipality	Supporting agencies	
	Establish Outpatient Therapeutic Care Centres (OTCCs) in all health facilities for Integrated Management of Acute Malnutrition (IMAM)				X						X				-	Health facility; Health section, *Ramgram* municipality	Supporting agencies	
	Conduct regular assessment of acute malnutrition at the community level	X	X	X	X	X	X	X	X	X	X	X	X	X	160,000	Health facility; Health section, *Ramgram* municipality	Supporting agencies	

HSS Objective 5: In 3 years, by FY 2080/81, 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	YEAR 1			YEAR 2			YEAR 3			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Support	Establish birthing centre with physical infrastructure and equipment in *Sukrauli* and *Manjariya* health facilities		X								X				1,000,000	*Ramgram* municipality		
	Approach Provincial Health Directorate and Training Centre for Skilled Birth Attendants' (SBA) training to the health workers		X								X	X			-	Health section, *Ramgram* municipality		
	Establish birthing centre with physical infrastructure and equipment in *Hakui*, *Jamuwad* and *Unwach* health facilities				X	X	X				X				1,500,000	*Ramgram* municipality		
	Manage physical infrastructure and equipment to run laboratory services in *Hakui*, *Jamuwad* and *Unwach* health facilities					X	X				X				900,000	*Ramgram* municipality	Supporting agencies	

HSS Objective 5: In 3 years, by FY 2080/81, 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	YEAR 1			YEAR 2			YEAR 3			Phase				Budget (in NPR)	Responsible	Supporting agencies	Remarks
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Normal	Alert	Serious	Emergency				
Support	Manage contractual health workers (Lab Assistant) to run laboratory services in *Hakui*, *Jamuwad* and *Unwach* health facilities					X	X	X	X	X	X				1,800,000	*Ramgram* municipality	Supporting agencies	
	Establish birthing centre with physical infrastructure and equipment in *Devgaun* health facility								X	X	X				18,500,000	*Ramgram* municipality		Type 'B' health facility
	Manage physical infrastructure and equipment to run laboratory services in *Devgaun* health facility								X	X	X				300,000	*Ramgram* municipality		
	Manage contractual health workers (Lab Assistant) to run laboratory services in *Devgaun* health facility								X	X	X				240,000	*Ramgram* municipality		

5 ANNEX

5.1 Annex 1: COMPOSITION OF THE STEERING COMMITTEE

S.N.	Position in SC	Organisation	Position in the Organisation	Name
1	Chair	*Ramgram* Municipality	Chair	Narendra Kumar Gupta
2	Co-chair	*Ramgram* Municipality	Chief Administrative Officer	Babulal Regmi / Rudra Prasad Regmi
3	Member Secretary	*Ramgram* Municipality	Health Coordinator	Krishna Prasad Chaudhary / Ram Naresh Ray
4	Member	USAID / SUAAHARA II Project	Programme Coordinator	Bharat Bhatta / Krishna Gurung
5	Member	Nepal Red Cross Society (NRCS), *Nawalparasi* West	President	Rajendra Agrahari
6	Member	Family Planning Association Nepal (FPAN)	Manager	Bishnu Gyawali
7	Member	Health Office, *Nawalparasi* West	Chief	Bhagwan Das Harijan / Gaurav Dhakal
8	Member	Federation of Nepal Chamber of Commerce and Industries (FNCCI), *Nawalparasi* West	Member	Urmila Baniya
9	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 November 2019

S.N.	Full name	Gender Male (M) Female (F) Other (O)	Designation	Organisation	Contact no.
1	Narendra Kumar Gupta	M	Mayor	*Ramgram* Municipality	9857046633
2	Badri Aalam	M			
3	Rajendra Prasad Agrahari	M	President	Nepal Red Cross Society	9857628111
4	Krishna Gurung	M	Programme Coordinator	SUAAHARA II	
5	Yashoda Paudel	M	Accountant	FPAN	
6	Narendra Prasad Bhattarai	M	Sr. AHW (6th)	*Amraut* Health Post	9847041023
7	Dr. Bipin Chaudhary	M	Medical Officer	*Prithvi Chandra* Hospital	9860700095
8	Roshan Kumar Shah	M	Member	*Ramgram* Municipality	9802650578
9	Ram Naresh Ray	M	Public Health Officer	*Ramgram* Municipality	9847036279
10	Urmila Baniya	F	Member	*Udhyog Banijya Sangh, Nawalparasi*	9857046802
11	Ratan Kumar Lal Das	M	Public Health Inspector	*Manjariya* Health Post	9841558488
12	Krishna Prasad Chaudhary	M	Public Health Officer	*Ramgram* Municipality	9867211866
13	Gaurav Dhakal	M	Chief	Health Office, *Nawalparasi* West	9801241701
14	Dr. Suraj Tiwari	M	Medical Officer	*Prithvi Chandra* Hospital	
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. Programme Officer	Action Against Hunger	9801187513
18	Bishnu Poudel	M	Technical Officer	Action Against Hunger	9801241701
19	Shirish Man Singh	M	Sr. Programme Officer	Action Against Hunger	

5.3 ANNEX 3: PARTICIPANTS OF HSS WORKSHOP 2

Workshop name: Cause identification
Date: 21-22 December 2019

S.N.	Full name	Gender Male (M) Female (F) Other (O)	Designation	Organisation	Contact no.
1	Narendra Kumar Gupta	M	Mayor	*Ramgram* Municipality	9857046633
2	Rudra Prasad Regmi	M	Chief Administration Officer	*Ramgram* Municipality	9857046721
3	Rajendra Prasad Agrahari	M	President	Nepal Red cross Society	9857628111
4	Janak Raj Khanal	M	Storekeeper/ NaSu	Health Office, *Nawalparasi* West	9848751081
5	Bishnu Gyawali	M	Manager	FPAN	9846774952
6	Bhagwan Tharu	M	Ward Chairman	*Ramgram* Municipality Ward 16	9847326263
7	Niyaj Ahmad Khan	M	Sr. AHW (6th)	*Hakui* Health Post	9847022705
8	Narendra Prasad Bhattarai	M	Sr. AHW (6th)	*Amraut* Health Post	9847041023
9	Daya Ram Napit	M	Sr. AHW (6th)	*Amarban* Health Post	9847079588
10	Gyanendra Prasad Chaudhary	M	Sr. AHW (6th)	*Devgaun* HP	9862560259
11	Rajkumar Shrestha	M	Sr. AHW (6th)	Unwach Health Post	9847299541
12	Balram Sapkota	M	Sr. AHW (6th)	*Sukrauli* Health Post	9847044150
13	Dr. Bipin Chaudhary	M	Medical Officer	*Prithvi Chandra* Hospital	9860700095
14	Roshan Kumar Shah	M	Member	*Ramgram* Municipality	9802650578
15	Ram Naresh Ray	M	Public Health Officer	*Ramgram* Municipality	9847036279
16	Binod Pokhrel	M	Nutrition Social Behaviour Change Communication Officer	SUAAHARA II	9851171658
17	Urmila Baniya	F	Member	*Udhyog Banijya Sangh, Nawalparasi*	9857046802
18	Ratan Kumar Lal Das	M	Public Health Inspector	*Manjariya* Health Post	9841558488

S.N.	Full name	Gender Male (M) Female (F) Other (O)	Designation	Organisation	Contact no.
19	Krishna Prasad Chaudhary	M	Public Health Officer	*Ramgram* Municipality	9867211866
20	Gaurav Dhakal	M	Chief	Health Office, *Nawalparasi* West	9801241701
21	Dr. Suraj Tiwari	M	Medical Officer	*Prithvi Chandra* Hospital	
22	Pashupati Nath Kohar	M	Nutrition Supervisor	Health Office, *Nawalparasi* West	9812961703
23	Dil Bahadur Khadka	M	Field Manager	Action Against Hunger	9801241745
24	Sujay Nepali Bhattacharya	M	Head of N&H department	Action Against Hunger	9801187510
25	Manisha Katwal	F	Sr. Programme Officer	Action Against Hunger	9801187513
26	Sujana Silwal	F	Technical Officer	Action Against Hunger	9801241703
27	Bishnu Poudel	M	Technical Officer	Action Against Hunger	9801241701
28	Ranjan Kapali	M	Sr. Programme Officer	Action Against Hunger	9801241742

5.4 ANNEX 4: PARTICIPANTS OF HSS WORKSHOP 3

Workshop name: Diagnosis phase
Date: 25-26 September 2020

S.N.	Full name	Gender Male (M) Female (F) Other (O)	Designation	Organisation	Contact no.
1	Narendra Kumar Gupta	M	Mayor	*Ramgram* Municipality	9857046633
2	Rajesh Panthi	M	Chief Administration Officer	*Ramgram* Municipality	9857628111
3	Rudra Prasad Regmi	M	Municipal Education Officer	*Ramgram* Municipality	9857023122
4	Rajendra Prasad Agrahari	M	President	Nepal Red cross Society	9857046721
5	Janak Raj Khanal	M	Storekeeper/ NaSu	Health Office, *Nawalparasi* West	9848751081
6	Bishnu Gyawali	M	Manager	FPAN	9846774952
7	Anil Khadka	M	Sr. AHW (6th)	*Ramgram* Municipality	9847027945
8	Krishna Prasad Pokharel	M	Acting Health Office	Health Office, *Nawalparasi* West	9857020348
9	Ramesh Kumar Pahari	M	PHI	*Jamuwad* HP	9847064326
10	Narendra Bhattarai	M	Sr. AHW (6th)	*Amraut* Health Post	9847041023
11	Narayan Bhattarai	M	Officer	Health Office, *Nawalparasi* West	9849028180
12	Balram Sapkota	M	Sr. AHW (6th)	*Sukrauli* Health Post	9847044150
13	Bhagwan Tharu	M	Ward Chairman	*Ramgram* Municipality Ward 16	9847326263
14	Niyaj Ahmad Khan	M	Sr. AHW (6th)	*Hakui* Health Post	9847022705
15	Daya Ram Napit	M	Sr. AHW (6th)	*Amarban* Health Post	9847079588
16	Chandra Bhawan Yadav	M	H.A	*Devgaun* HP	9844718591
17	Rajkumar Shrestha	M	Sr. AHW (6th)	Unwach Health Post	9847299541
18	Dr. Bipin Chaudhary	M	Medical Officer	*Prithvi Chandra* Hospital	9860700095
19	Roshan Kumar Shah	M	Member	*Ramgram* Municipality	9802650578

S.N.	Full name	Gender Male (M) Female (F) Other (O)	Designation	Organisation	Contact no.
20	Ram Naresh Ray	M	Public Health Officer	*Ramgram* Municipality	9847036279
21	Urmila Baniya	F	Member	*Udhyog Banijya Sangh, Nawalparasi*	9857046802
22	Ratan Kumar Lal Das	M	Public Health Inspector	*Manjariya* Health Post	9841558488
23	Sunil Lamichhane	M	NaSu	*Ramgram* Municipality	9857045317
24	Sudikshya Basnet	F	Nutrition Information Management Officer	Health Office, *Nawalparasi* West	9842369615
25	Sher Singh Dahit	M	Field Manager	Action Against Hunger	9801241745
26	Sujay Nepali Bhattacharya	M	Head of N&H department	Action Against Hunger	9801187510
27	Manisha Katwal	F	Sr. Programme Officer	Action Against Hunger	9801187513
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: 02-03 October 2020

S.N.	Full name	Gender Male (M) Female (F) Other (O)	Designation	Organisation	Contact no.
1	Narendra Kumar Gupta	M	Mayor	*Ramgram* Municipality	9857046633
2	Rajesh Panthi	M	Chief Administration Officer	*Ramgram* Municipality	9857628111
3	Rudra Prasad Regmi	M	Municipal Education Officer	*Ramgram* Municipality	9857023122
4	Rajendra Prasad Agrahari	M	President	Nepal Red cross Society	9857046721
5	Janak Raj Khanal	M	Storekeeper / NaSu	Health Office, *Nawalparasi* West	9848751081
6	Bishnu Gyawali	M	Manager	FPAN	9846774952
7	Anil Khadka	M	Sr. AHW (6th)	*Ramgram* Municipality	9847027945
8	Krishna Prasad Pokharel	M	Acting Health Office	Health Office, *Nawalparasi* West	9857020348
9	Ramesh Kumar Pahari	M	PHI	*Jamuwad* HP	9847064326
10	Narendra Bhattarai	M	Sr. AHW (6th)	*Amraut* Health Post	9847041023
11	Narayan Bhattarai	M	Officer	Health Office, *Nawalparasi* West	9849028180
12	Balram Sapkota	M	Sr. AHW (6th)	*Sukrauli* Health Post	9847044150
13	Bhagwan Tharu	M	Ward Chairman	*Ramgram* Municipality Ward 16	9847326263
14	Niyaj Ahmad Khan	M	Sr. AHW (6th)	*Hakui* Health Post	9847022705
15	Daya Ram Napit	M	Sr. AHW (6th)	*Amarban* Health Post	9847079588
16	Chandra Bhawan Yadav	M	H.A	*Devgaun* HP	9844718591
17	Rajkumar Shrestha	M	Sr. AHW (6th)	Unwach Health Post	9847299541
18	Dr. Bipin Chaudhary	M	Medical Officer	*Prithvi Chandra* Hospital	9860700095
19	Roshan Kumar Shah	M	Member	*Ramgram* Municipality	9802650578

S.N.	Full name	Gender Male (M) Female (F) Other (O)	Designation	Organisation	Contact no.
20	Ram Naresh Ray	M	Public Health Officer	*Ramgram* Municipality	9847036279
21	Urmila Baniya	F	Member	*Udhyog Banijya Sangh, Nawalparasi*	9857046802
22	Ratan Kumar Lal Das	M	Public Health Inspector	*Manjariya* Health Post	9841558488
23	Sunil Lamichhane	M	NaSu	*Ramgram* Municipality	9857045317
24	Sudikshya Basnet	F	Nutrition Information Management Officer	Health Office, *Nawalparasi* West	9842369615
25	Sher Singh Dahit	M	Field Manager	Action Against Hunger	9801241745
26	Sujay Nepali Bhattacharya	M	Head of N&H department	Action Against Hunger	9801187510
27	Manisha Katwal	F	Sr. Programme Officer	Action Against Hunger	9801187513
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: 05 December 2020

S.N.	Full name	Gender Male (M) Female (F) Other (O)	Designation	Organisation	Contact no.
1	Narendra Kumar Gupta	M	Mayor	*Ramgram* Municipality	9857046633
2	Rajesh Panthi	M	Chief Administration Officer	*Ramgram* Municipality	9857628111
3	Rudra Prasad Regmi	M	Municipal Education Officer	*Ramgram* Municipality	9857023122
4	Suraj Harijan	M	HA	*Ramgram* Municipality	9857070243
5	Janak Raj Khanal	M	Storekeeper/ NaSu	Health Office, *Nawalparasi* West	9848751081
6	Bishnu Gyawali	M	Manager	FPAN	9846774952
7	Anil Khadka	M	Sr. AHW (6th)	*Ramgram* Municipality	9847027945
8	Krishna Prasad Pokharel	M	Acting Health Office	Health Office, *Nawalparasi* West	9857020348
9	Sapana Khadka	F	AFO	BES Nepal	9847437911
10	Narendra Bhattarai	M	Sr. AHW (6th)	*Amraut* Health Post	9847041023
11	Narayan Bhattarai	M	Officer	Health Office, *Nawalparasi* West	9849028180
12	Balram Sapkota	M	Sr. AHW (6th)	*Sukrauli* Health Post	9847044150
13	Bhagwan Tharu	M	Ward Chairman	*Ramgram* Municipality Ward 16	9847326263
14	Niyaj Ahmad Khan	M	Sr. AHW (6th)	*Hakui* Health Post	9847022705
15	Daya Ram Napit	M	Sr. AHW (6th)	*Amarban* Health Post	9847079588
16	Krishna Gurung	M	PC	SUAAHARA II	9801198597
17	Rajkumar Shrestha	M	Sr. AHW (6th)	Unwach Health Post	9847299541
18	Dr. Bipin Chaudhary	M	Medical Officer	*Prithvi Chandra* Hospital	9860700095
19	Roshan Kumar Shah	M	Member	*Ramgram* Municipality	9802650578
20	Ram Naresh Ray	M	Public Health Officer	*Ramgram* Municipality	9847036279

S.N.	Full name	Gender Male (M) Female (F) Other (O)	Designation	Organisation	Contact no.
21	Urmila Baniya	F	Member	*Udhyog Banijya Sangh*, Nawalparasi	9857046802
22	Ratan Kumar Lal Das	M	Public Health Inspector	*Manjariya* Health Post	9841558488
23	Sunil Lamichhane	M	NaSu	*Ramgram* Municipality	9857045317
24	Santosh Gurung	M	Sr. A.H.W.	*Manjariya* HP	9847027512
25	Saroj Dhital	M	Station Manager	*Triveni* television	9845434195
26	Sher Singh Dahit	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. Programme Officer	Action Against Hunger	9801187513
29	Sujana Silwal	F	Technical Officer	Action Against Hunger	9801241703
30	Bishnu Poudel	M	Technical Officer	Action Against Hunger	9801241701
31	Ranjan Kapali	M	Sr. Programme Officer	Action Against Hunger	9801241742

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	Impoverished 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	Impoverished 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 polices	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 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 enrolees	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	Impoverished 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 BHCP 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	Impoverished 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 reimbursements
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