

# ANNUAL REPORT

FY 2081/82 (2024/25)



**Lumbini Province Government**  
**Ministry of Health**  
**Health Directorate**

**Health Office, Rolpa**

# Annual Report

FY 2081/82 (2024/25)



Lumbini Province Government  
Ministry of Health  
Health Directorate  
**Health Office, Rolpa**

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**Lumbini Province Government**  
**Ministry of Health**  
**Rapti Valley (Deukhuri) Dang, Nepal**

**Hon. Khem Bahadur Saru**  
**Minister**



## MESSAGE FROM THE MINISTER



I am delighted to know that the Health Office Rolpa is releasing the annual report for the fiscal year 2081/82, providing a comprehensive overview of the performance across all components of the district's healthcare delivery system, in coordination with local governments.

The health ministry is committed to providing quality health services to all the people within the province. The ministry is also determined to achieve universal health coverage (UHC) together with all stakeholders including public, private and non-governmental sectors.


Several outstanding achievements have been made in health sector in past decades. Nepal's average life expectancy has improved steadily, reaching 72.19 years; Maternal Mortality Rate (MMR) is 151 per 100,000 live births. Infant Mortality Rate (IMR) 22.06 per 1,000 live births. Likewise the percentage of institutional deliveries of Rolpa has increased from 65.54% to 68.19% now.

However, there remain challenges that we must continue to address Geographic remoteness, limited infrastructure, shortage of human resource and need of out of pocket expenditure are persistent barriers to health care access in this region. We are committed to overcome these obstacles by investing in infrastructure development, training more healthcare professionals, and expanding health services to the most underserved population.

I extend my best wishes to entire Health Office Rolpa team for the commendable progress made so far and I am confident that continued dedication will bring even greater advancements in healthcare of the district in the near future.

Let us strive forward with renewed determination in the coming years, knowing that physical, mental and social well-being of our citizens is at the heart of our nation's progress.

November 2, 2025

  
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Hon. Khem Bahadur Saru  
मन्त्री  
स्वास्थ्य मन्त्रालय



Ref:



Lumbini Province Government  
**Ministry of Health**  
Rapti Valley,(Deukhuri) Dang, Nepal



## PREFACE

It is a matter of great pleasure for me to have Annual Report of Health Office Rolpa for the Fiscal Year 2081/82. This report is being published on a regular basis for a long time. It is a comprehensive report covering all the activities and achievements of the district & the local levels within the district. This kind of report not only presents past performance but also supports for a robust and evidence-based planning. I believe that the information provided in this report will be of an immense use to planners, researchers, managers, service providers and relevant stakeholders.

This comprehensive report covers all the major health sector activities of the district & below including the contribution from the supporting partners. I am confident that a competent and efficient health care delivery system is in place and all the relevant data from the community to district level are included in this report.

I also would like to point out that while celebrating the success, we should be aware that sustained efforts are needed to accelerate the effort we have made. Still there are many areas to improve and shape up the health sector achievements in the federal context. It is strongly felt that additional efforts are required to maintain the quality in health service delivery thereby ensuring equity and equality in opportunities.

Finally, I highly appreciate the entire staff of Health Office Rolpa for the hard work accomplished by dedication to ensure the quality of health care services. I acknowledge to all the health service workforces including Female Community Health Volunteers (FCHVs) & external health partners for achieving these outcomes. They deserve whole hearted thanks for improving health status of the citizens of the entire province.

November 2, 2025

  
Durga Laxmi Shrestha  
Province Secretary  
सचिव



लुम्बिनी प्रदेश सरकार  
स्वास्थ्य मन्त्रालय

## स्वास्थ्य निर्देशनालय

राप्ती उपत्यका (देउखुरी), नेपाल

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च.नं.:



मिति : २०८२/०७/११


### सन्देश

स्वास्थ्य कार्यालय रोल्पाले जिल्ला स्तरीय वार्षिक कार्य सम्पादन समीक्षा गोष्ठी सम्पन्न गरी आर्थिक वर्ष २०८१/८२ को समग्र वार्षिक प्रतिवेदन प्रकाशन गर्न लागेको थाहा पाउँदा मलाई धेरै खुसी लागेको छ। यो प्रतिवेदनले स्वास्थ्य कार्यालय मार्फत सञ्चालित गत आर्थिक वर्षको कार्य प्रगतिको अवस्था प्रस्तुत गरेको छ। यसले सबल पक्षहरु आत्मसात गर्दै सुधार गर्नुपर्ने पक्षहरुमा केन्द्रित हुन र तथ्यमा आधारित योजना तर्जुमाका लागि पनि सहयोग पुऱ्याउने नै छ। यस प्रतिवेदनमा उपलब्ध तथ्याङ्क तथा जानकारीहरु योजनाकार, नीति निर्माता, निर्णयकर्ता, अनुसन्धानकर्ता, व्यवस्थापक, स्वास्थ्य सेवा प्रदायक, विद्यार्थी र सम्बन्धित सरोकारवालालाई समेत उपयोगी हुनेछ।



यस प्रतिवेदनमा प्रस्तुत तथ्याङ्क र विश्लेषणले रोल्पा जिल्लाको स्वास्थ्य प्रणालीको अवस्था बारे स्पष्ट जानकारी दिन्छ। प्रतिवेदनले गत आर्थिक वर्षमा धेरै क्षेत्रहरुमा प्रगति भएको सङ्केत गरेको छ, तर स्वास्थ्य सेवा प्रवाहमा सहज पहुँच र गुणस्तर कायम राख्न भने थप प्रयासहरुको आवश्यकता देखिन्छ। प्रतिवेदनले जिल्ला र विभिन्न स्थानीय तहबाट विगत तीन आर्थिक वर्षमा सम्पादित स्वास्थ्य सम्बन्धी प्रमुख कार्यक्रम तथा गतिविधिहरुको कार्यान्वयन र प्रगतिको अवस्था, सबल पक्ष, अवसर तथा चुनौतीहरु र समस्या समाधानका उपायहरु लगायतका विषयवस्तुहरु समेटेको छ। साथै यसले स्वास्थ्य विकास साभेदार संघसंस्थाहरु र निजी क्षेत्रहरुको योगदानलाई पनि समेटेको छ।

रोल्पा जिल्लाको स्वास्थ्य सेवालाई सबल र सुदृढ गर्न मद्दत पुर्याउने संघ, प्रदेश तथा स्थानीय तह एवं सरकारी तथा गैर-सरकारी संघ संस्थाहरु र विकास साभेदार संस्थाहरु लगायत सम्पूर्ण सहयोगी हातहरुलाई धन्यवाद ज्ञापन गर्दछु। यो विस्तृत वार्षिक स्वास्थ्य प्रतिवेदन तयार पार्ने कार्यमा संलग्न स्वास्थ्य कार्यालय रोल्पाका सम्पूर्ण कर्मचारीहरु प्रति म हार्दिक आभार व्यक्त गर्दछु।

  
रोशनलाल चौधरी  
निमित्त निर्देशक  
रोशन लाल चौधरी  
निमित्त निर्देशक

“राज्यको सबै तहमा स्वास्थ्य सेवाको पूर्वाधार, गुणस्तरीय र जनमुखी स्वास्थ्य सेवा, सम्बृद्धि एवम दिगो विकासको आधार”



**Lumbini Province Government**  
**Ministry of Health**  
**Health Directorate**  
**Health Office, Rolpa**

Date: 2082/07/14



Ref No:

## FOREWORD

It is my pleasure to express few words regarding this annual report of Health Office, Rolpa for the FY 2081/82. This report is one of the outcomes of the annual performance review workshop conducted at the district level.



It provides the summary of performance of each health program in terms of targets and achievements for the FY 2081/82. In addition, the performance of health program activities has been compared with the result of the three years. The data presented in this report are based on the information submitted by health institutions, Immunization clinics, PHC/ORCs, FCHVs, non-governmental organization and private sectors throughout the district. In this report, different health plan, policies and strategies have been included. It also includes program-wise activities, target VS achievement, issues/challenges and recommendations.

I would like to extend my deepest gratitude to all district supervisors and staffs, hospital staffs, HF incharges, peripheral health workers and all Female Community Health Volunteers (FCHVs) for their vital roles, year-round efforts and active performance in bringing about progressive output in the FY 2081/82 and also would like to welcome for further improvement qualitatively in coming fiscal year. I would like to express my appreciation to Mr. Arun V2 Upadhaya (Officer Statistics) & all the HO staffs who took the full responsibility to complete this comprehensive annual health report.

Finally, I would like to express my sincere thanks to DCC, Municipalities/Rural Municipalities, Line agencies, Partner organization, Private sectors, Community leaders, Political parties and media persons for their co-operation and support to deliver quality health care services throughout the district.

*Sita Kanwor*

Sita Kanwor  
Acting. Health Office Chief

स्वास्थ्य कार्यालय प्रमुख

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his annual report is an important summary status of Health Office, Rolpa that includes progress of different health programs within the district in fiscal year 2081/82 BS. It also incorporates a comparative status of these programs over last three years. Furthermore, this report represents the brief of national plans and policies, district level activities carried out, problems/constraints and respective recommendations to address the problems. The data presented here are collected from the HMIS through 126 HF including Government, Private Health facilities, Hospital along with NGO. 182 PHC/ORCs, 219 Immunization Clinics, 459 FCHVs of all local level government and more than half dozen of external development partners are along with us.

#### National Immunization Program:

Immunization coverage of <2-year children has near to 90% in the last three Fiscal Years (FYs). Coverage of BCG is 85 % in FY 2081/82 which has increased as compared to previous year. Coverage of DPT/HepB/HiB-3 has slightly decreased this year than last FY from 92.57% in 2080/81 to 92.4% in 2081/82. Coverage of measles-rubella (2<sup>nd</sup>) has increase in FY 2081/82 i.e. 105.4.7%. However the coverage of all antigens is inconsistent way. Coverage of TD has been increased i.e. 66.70% to 74.00% in last two fiscal year. Dropout rate of DPT-HepB-Hib1 vs MR2 is -10.93% in FY 2081/82.

#### CB-IMNCI Program

Incidence of ARI/1000 <5-year children is in increasing trend from 770 /1000 in FY 2080/81 to 869/1000 in FY 2081/82. Incidence of diarrhea/1000 <5 years children has been increased to 251 in 2080/81 as compared 261 in 2081/82.

#### Nutrition Program

The average number of visits among children aged 0-23 months registered for growth monitoring is in increasing trend. 17.46 was in FY 2080/81 and now it was 20.09 in FY 2081/82. New Growth Monitoring <1 year has been increased to 97.88 % in FY 2081/82 whereas it was 94 % in FY 2080/81. Percentage of pregnant women receiving 180 iron tablets has increased from 64.43% to 76.61 %. The percentage of post-partum mothers receiving Vitamin A has also increased during FY 2081/82 i.e. 104.5%

#### Maternal and Newborn Health Program

Percentage of ANC 1<sup>st</sup> visit as per protocol has significantly increased to 85.32% in FY 2081/82 as compare to 76.30 % in FY 2080/81. Similarly, 76.45% of pregnant women have made complete 4 ANC visits in FY 2081/82. Similarly 8 ANC visits has been increasing from 53.89 % to 60.96 %. 68.19 % of institutional deliveries have been made in this fiscal year among which, 48.91.% of deliveries have been conducted by SBA trained ANM. Likewise, 73.08% of women had their 4 PNC visits.

#### Family Planning and Reproductive Health Program

The Contraceptive Prevalance Rate (CPR) unadjusted among women of reproductive age (WRA) is increased from 32.3 in FY 20780/81 to 44.96 in FY 2081/82. The new acceptors as percentage of WRA is 4.73% in FY 2081/82.

#### Adolescent Sexual and Reproductive Health Program

In FY 2081/82, Altogether 38 health facilities in the district are certified for the quality adolescent friendly program and services and additional few HF's have pre-certified during the FY 2081/82 and other health facilities are in pipeline in certification process.

**Primary Health Care/ Out Reach Clinics:**

Altogether 182PHC/ORC clinics have been running in the district and average number of people served per clinic has increased to 22.13in FY 2081/82as comparedto fiscal year 2080/81.

**TB Control Program:**

The Case Notification Rate of all forms of TB has been decreased to 107 per 100000 in FY 2081/82 as of 134 per 100000 in FY 2080/81, Treatment success rates is93.4 % which seems good, which is higher than the global target of 90%.

**Leprosy Control Program:**

New case detection rate is 0.13per 100000 populationin FY 2081/82which is decreased in comparisonwithFY 2080/81. There are total 3 new leprosy cases under treatment throughout the district. Leprosy prevalence rate is found to be 0.13 in FY 2081/82.

**Malaria Control Program:**

Annual blood slidecollection and examinationby health facilities are seen is in increasing trends. Along with RDT and Blood Slide collection, 4713 samples have been tested in FY 2081/82, while 2681 are tested in FY 2080/81. There are 3 imported malaria positive case in FY 2081/82.

**HIV/AIDS Program**

The Percentage of pregnant women who tested for HIV at an ANC checkup is 91 %.The cumulative reported cases of HIV in Rolpaareincreasing in which 48 HIV cases are on treatment in ART center (Rolpa Hospital)

**Female Community Health Volunteer Program**

Total 459 FCHV's have been working in different communities throughout the district. They have conducted Mother's group meeting99.54% in FY 2081/82. The average number of people served by FCHV per month is 25.34 in 2081/82.

**OPD Services:**

The percentage of new OPD Visits among total population has increased in FY 2081/82.

## DISTRICT FACT SHEET (THREE YEARS COMPARISON)

INDICATORS	2079/80	2080/81	2081/82
<b>HMIS/DHIS-2 REPORTING STATUS</b>			
% of Public Hospital Reporting Status	100	100	100
% of Public HF Reporting Status	100	100	100
% of PHC/ORC Clinics Reporting Status	97.3	100	100
% of EPI Clinics Reporting Status	99.32	99.02	91.81
% FCHVs Reporting Status	98.8	99.46	99.67
<b>IMMUNIZATION COVERAGE</b>			
% of children under one year immunized with BCG	84	85	85
% of children under one year immunized with DPT-HepB-Hib1	90.12	91.51	91.78
% of children under one year immunized with DPT-HepB-Hib3	87.3	92.57	92.4
% of children under one year immunized with PCV 1	90.05	91.51	91.78
% of children under one year immunized with PCV 3	85.99	93.59	94.72
% of children under one year immunized with FIPV 1st	78.74	92.34	92.16
% of children under one year immunized with FIPV 2nd	56.66	94.16	94.75
% of children aged 9-11 months immunized with Measles/Rubella 1st	85.95	93.53	94.8
% of children aged 12-23 months immunized with Measles/Rubella 2	86.21	94.73	105.4
% of children immunized with Rota First	89.67	91.49	91.61
% of children immunized with Rota Second	87.22	91.64	91.28
% of children aged 12-23 months immunized with Typhoid Vaccine	86.23	94.93	105.33
% of children fully immunized as per NIP Schedule	63	66	74
% of Pregnant women immunized by TD 2 and 2+	63	66	74
Dropout Rate DPT-HepB-Hib1 Vs DPT-HepB-Hib3	3.13	-1.16	-0.68
Dropout Rate DPT-HepB-Hib1 Vs MR2	4.23	-2.64	-10.93
Average number of People served by Per PHC/ORC	21.75	23.81	22.13
Average number of People served by Per Immunization Clinic	14.21	13.5	13.87
<b>CB-IMNCI PROGRAM</b>			
Incidence of ARI among children U 5 Yrs (Per1000)	728	770	869
Incidence of Pneumonia among children U 5 Yrs (Per1000)	89.1	94.4	96.5
Incidence of Diarrhoea among children U 5 Yrs (Per1000)	208	251	261
% of Antibiotics Treatment who suffered from Pneumonia	100	100	100
% of children U 5 yrs with diarrhoea treated with ZINC and ORS	100	100	100
% of children U5 yrs suffering from severe dehydration	0.02	0.24	0.17
<b>NEWBORN CARE</b>			
% of infants aged 0-2 months with Local Bacterial Infection	32.5	29.2	28.38
% of infants aged 0-2 months with PSBI	9.45	7.74	6.18
% of infants aged 0-2 months with PSBI receiving a first dose of Gentamycin	96.49	98.25	102.13
% of infants aged 0-2 months with PSBI receiving a complete dose of Gentamycin	57.9	57.9	53.19
<b>NUTRITION PROGRAM</b>			
% of children aged 0-11 months registered for growth monitoring	90.7	94	97.88
% of 0-23 months aged children registered and visited for Growth Monitoring who were underweight	1.6	1.3	1.2

## Health Office, Rolpa

INDICATORS	2079/80	2080/81	2081/82
% of children aged 12-23 months newly registered for growth monitoring	7.1	3.8	3
Average number of visits among children aged 0-23 months registered for Growth Monitoring	13.8	17.46	20.09
% of children aged 6-59 months who received vitamin A supplementation in last six months	98.3	98.6	104.5
<b>MATERNAL AND NEONATAL HEALTH</b>			
% of Pregnant women who had at least one ANC checkup	91.33	92.34	101.23
% of Pregnant women who had first ANC checkup as per protocol	67.15	76.30	85.32
% of Pregnant women attending 4 ANC checkups as per protocol	64.06	69.41	76.45
% of Pregnant women attending 8 ANC checkups as per protocol	23.87	53.89	60.96
% of women who received 180 days supply of IFA during pregnancy	64.91	69.43	76.61
% of institutional deliveries	66.72	65.54	68.19
% of Births attended by SBA Trained ANM	41.89	46.21	48.91
% of Postpartum women who received Vitamin 'A' Supplements	98.83	98.64	104.5
No of CAC (Surgical and Medical Abortion, MA)	969	943	914
No of PAC Services	113	86	112
% of women receiving maternity incentives among total institutional deliveries	100	100	99.90
% of women receiving 4 ANC incentives among total institutional deliveries	100	100	99.84
% of women who had first PNC visit within 24 hours	66.30	66.26	68.38
% of women who had 3 PNC visits	67.37	71.30	77.74
% of women who had 4 PNC visits	48.46	62.02	73.08
No of Home Delivery	71	95	34
Total Neonatal Deaths	20	4	5
Total Maternal Deaths	4	0	7
<b>FAMILY PLANNING</b>			
Contraceptive Prevalence Rate (CPR, WRA, Unadjusted)	32.7	32.3	44.96
FP new acceptors as % of MWRA( All modern FP methods)	5.87	4.44	4.73
% of PPM using a modern contraceptive method	17.72	18.63	34.89
FP new user total- IUCD	38	51	60
FP new user total- Implant	799	715	665
CYP-Condoms	3198.8	3929.24	5883.88
Current Users – Pills	1155	1150	1186
Current Users – Depo	4257	4227	4325
Current Users – IUCD	860	860	890
Current Users – Implant	8470	8358	7992
Current Users – Sayana Press	927	871	970
<b>TUBERCULOSIS PROGRAM</b>			
Case notification rate, CNR (all forms of TB cases)	119.7	134.6	108.4
Case notification rate, CNR (New and Relapse cases)	118.45	133.75	107.11
Treatment success rate, TSR (New and Relapse Cases)	94.24	93.43	92.95
Deaths due to Tuberculosis	3	3	4

**Health Office, Rolpa**

<b>INDICATORS</b>	<b>2079/80</b>	<b>2080/81</b>	<b>2081/82</b>
<b>LEPROSY PROGRAM</b>			
New case Detection Rate (NCDR)	2.1	3.9	1.3
Prevalence Rate per 10000 population	0.21	0.39	0.13
Total No of Leprosy New Cases	5	9	3
Number of grade 2 disability among new cases	0	11.1	0
<b>MALARIA PROGRAM</b>			
Totalno of blood slides collection (ACD+PCD)	1126	2681	4713
Test Positivity Rate (TPR)	0.09	0	0.06
Annual Parasite Incidence (API)	0	0	0
Annual Blood Examination Rate (ABER)	0	1.16	0
No of Malaria positive cases	1	0	3
<b>HIV/AIDS AND STI PROGRAM</b>			
Total Number of HIV tested in HTC Program	3604	242	264
Number of New HIV Positive Cases	1	0	3
Total number of HIV Positive Cases	67	67	70
Number of HIV cases on ART	46	48	46
Number of PMTCT Tested during ANC	4301	4828	4602
% of pregnant women with known HIV status	63.5	85.3	91
<b>FEMALE COMMUNITY HEALTH VOLUNTEER</b>			
Total No of FCHV	459	459	459
% of Mother's Group Meeting held	97.56	99.09	99.54
Average number of People served by FCHVs Per Month	26.31	26.15	25.34
<b>PHC/ORC PROGRAM</b>			
Total No. of PHC/ORC Clinics	175	178	182
Average People served per Clinic	21.75	23.81	22.13
<b>CURATIVE SERVICES</b>			
Total Outpatient OPD new visits	164141	176607	144997
% of outpatient (OPD) new visits among total population	68.46	76.19	62.36
Proportion of Female patients among total new OPD visits	0.61	0.46	0.62

### ABBREVIATIONS

ACD	Active Case Detection
ACF	Active Case Finding
AEFI	Adverse Events Following Immunization
AFP	Acute Flaccid Paralysis
AFR	Adolescent Fertility Rate
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Anti Retro Viral Therapy
ASBA	Advanced Skilled Birth Attendant
ASRH	Adolescent Sexual and Reproductive Health
BC	Birthing Centre
BCC	Behavior Change Communication
BEONC	Basic Emergency Obstetric and Neonatal Care
BHSC	Basic Health Service Center
BMI	Body Mass Index
BNMT	Birat Nepal Medical Trust
CAC	Comprehensive Abortion Care
CBOs	Community Based Organizations
CB-IMCI	Community Based Integrated Management of Childhood Illnesses
CEONC	Comprehensive Emergency Obstetric and Neonatal Care
CHU	Community Health Unit
CMYP	Comprehensive Multiyear Immunization Plan
CMS	Central Medical Store
CNSI	Comprehensive Nutrition Specific Intervention
CPR	Contraceptive Prevalence Rate
CSE	Comprehensive Sexuality Education
DCC	District Coordination Committee
DOHS	Department of Health Services
EDCD	Epidemiology and Disease Control Division
EHCS	Essential Health Care Service
ELB	Expected Live Births
EPI	Expanded Program on Immunization
EWARS	Early Warning and Reporting System
FCHV	Female Community Health Volunteer
FP	Family Planning
GESI	Gender Equality and Social Inclusion
GoN	Government of Nepal
HCT	HIV Counseling and Testing
HD	Health Directorate
HF	Health Facility
HFOMC	Health Facility Operation and Management Committee

HKI	Hellen Keller International
HIV	Human Immune deficiency Virus
HMG	Health Mother's Group
HMIS	Health Management Information System
HO	Health Office
HP	Health Post
HTC	HIV Testing and Counseling
ICT	Information Communication and Technology
IDA	Iron Deficiency of Anemia
IDD	Iodine Deficiency Disorder
IEC	Information Education Communication
IFA	Iron Folic Acid
IPC	Infection Prevention and Control
IMR	Infant Mortality Rate
IUCD	Intra-Uterine Contraceptive Device
JE	Japanese Encephalitis
KIDS	Kapilvastu Integrated Development Services
KP	Key Population
LARC	Long Acting Reversible Contraceptive
LLG	Local Level Government
MAM	Moderate Acute Malnutrition
MDA	Mass Drug Administration
MDR	Multi Drug Resistance
MH	Mental Health
MHM	Menstrual Health Management
MMR	Maternal Mortality Rate
MNP	Multi Micronutrient Powder
MOH	Ministry of Health
MPDSR	Maternal and Perinatal Deaths Surveillance and Response
MRSD	Measles-Rubella Second Dose
MSS	Minimum Service Standards
MSNP	Multi Sector Nutrition Plan
NCD	Non-Communicable Diseases
NDHS	Nepal Demographic and Health Survey
NHEICC	National Health Education, Information and Communication Centre
NHSP	Nepal Health Sector Program
NIP	National Immunization Program
NTD	Neglected Tropical Diseases
OCMC	One Stop Crisis Management Center
OPD	Outpatient Department
OTC	Outpatient Therapeutic Care

PAC	Post Abortion Care
PBC	Pulmonary Bacteriologically Confirmed
PCD	Passive Case Detection
PEM	Protein Energy Malnutrition
PEN	Package of Essential Non-Communicable Diseases
PHC/ORC	Primary Health Care Outreach Clinics
PHCC	Primary Health Care Center
PHLMC	Provincial Health Logistic Management Center
PMTCT	Prevention of Mothers to Child Transmission
PNC	Post Natal Care
PPHL	Provincial Public Health Laboratory
RDQA	Routine Data Quality Assurance
RED	Reaching Every District
RM	Rural Municipality
RMNCAH	Reproductive Maternal, Newborn, Child and Adolescent Health
RRN	Rural Reconstruction Nepal
RRT	Rapid Response Team
RUSG	Rural Ultra Sono-Graphy
SAM	Severe Acute Malnutrition
SARC	Short Acting Reversible Contraceptive
SDG	Sustainable Development Goals
SDP	Service Delivery Point
SHN	School Health Nurse
SNCU	Special Newborn Care Unit
STI	Sexually Transmitted Infection
TB	Tuberculosis
TBPT	Tuberculosis Preventive Therapy
UHC	Urban Health Clinic
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VAD	Vitamin A Deficiency Disorder
VIA	Visual Inspection with Acetic Acid
VPD	Vaccine Preventable Diseases
VSC	Voluntary Surgical Contraception
WRA	Women of Reproductive Age
WASH	Water Hygiene and Sanitation

## INTRODUCTION

### 1.1 Background

The Good Governance Act, 2008, specifies the submission of an annual progress report to the higher authority. Based on that act Health Office (HO), Rolpa has prepared an annual health report, which is the fundamental part of the Health Management Information System (HMIS). This report has been prepared after the completion of the district-level annual review meeting, followed by the municipal-level review meeting. It is the outcome of relevant information on annual performances of all the health programs and activities carried out during the FY 2081/82 through the network of health service outlets of Rolpa. It also analyzes the annual trends of progress based on the major key program indicators and achievements against the target set with regard to the last three fiscal years, i.e., 2079/80 to 2081/82. In addition, it highlights the problems/constraints identified while carrying out the activities in the district and suggests respective recommendations for related stakeholders.

This is the sequential report of its kind and is the eighth annual health report of HO Rolpa after restructuring the health system based on federalization. This report includes information related to the district health system, which can help in managing district health programs. With the organization and leadership of the local level government, the local level annual review workshop was conducted with full participation and involvement of HO staff, municipal health workers, and I/NGOs, and others. Along with this, a two-day district-level review workshop was also conducted in the participation of the HO team, line agencies, development partner, and municipal health coordinators based on directives, norms, and format set by the Management Division (MD), Department of Health Services (DoHS), and Ministry of Health (MoH) of Lumbini Province. Session wise panel discussion was carried out with indicator-based presentations, discussions, and review, analysis, and recommendations of each program. Indicators and municipal health facilities with satisfactory progress, good practices were appreciated, and those with low performances were provided ways forward for improvement in the coming days.

**This report covers the following areas:**

- Highlights of major guiding policies and plans like the Sustainable Development Goals (SDGs), Constitution of Nepal 2072 B.S., National Health Policy 2076 B.S., National Population Policy 2082 B.S., Sixteenth Five-Year Plan (2024-2029), Local Governance Operation Act of Nepal 2074 B.S., Health Policy of Lumbini Province 2077 B.S., and Second Five-Year Plan of Lumbini Province (2081/82-2085/86 B.S.).

- Overview of Rolpa District and Health Office Structure and Systems.
- Program-specific information, viz. background, vision, goal, objectives, strategies and targets, major indicators and trends analysis of service statistics, major activities conducted reporting period and issues, issues/challenges, and recommendations,
- Curative services and supporting programs, and supporting partners working with HO on various programs, etc.

## 1.2. Policies and Plans

१.२.१. प्रदेश स्वास्थ्य नीति, २०७७ (लुम्बिनी प्रदेश)

नेपालको संविधानले निःशुल्क आधारभूत तथा आकस्मिक स्वास्थ्य सेवालाई मौलिक हकको रूपमा स्थापित गरेको छ। देश संघीय शासन प्रणालीमा रूपान्तरण भइसकेको अवस्थामा स्वास्थ्य सेवाका संरचना तथा सेवा प्रणाली संघ, प्रदेश र स्थानीय गरि तीन तहमा विभाजन गरिएको छ। संघीय संरचनामा गुणस्तरीय स्वास्थ्य सेवामा सर्वव्यापी पहुँच पुर्याउने प्रदेशको समेत दायित्व रहेको छ। संविधान बमोजिम विभिन्न तहले सम्पादन गर्ने कार्यहरूको अधिकार सूची, संघीय नीति तथा कार्यक्रमहरू, दिगो विकास लक्ष्य, नेपालले विभिन्न समयमा गरेका अन्तर्राष्ट्रिय प्रतिबद्धताहरू एवम् प्रदेशमा स्वास्थ्य क्षेत्रभित्रका समस्या र चुनौतीहरू, प्रदेश नीति, प्रदेशमा उपलब्ध साधन र स्रोत, तथ्य तथा प्रमाणहरूलाई समेत विश्लेषण गरी प्रदेशको स्वास्थ्य नीतिका प्राथमिकता तयगरिएको छ। यसैको आधारमा प्रदेशको समृद्धका लागि समृद्ध प्रदेश खुसी जनता भन्ने दीर्घकालीन सोचलाई सार्थक तुल्याउन प्रदेश स्वास्थ्य नीति, २०७७ तर्जुमा गरीजारी गरिएको छ।

### भावी सोच (Vision)

समृद्ध प्रदेशका लागि स्वस्थ र खुसी नागरिक।

### ध्येय (Mission)

प्रदेशवासीको स्वस्थ रहन पाउने मौलिक हकको सुनिश्चितता गर्ने।

### लक्ष्य (Goal)

समतामूलक एवम् सुदृढ स्वास्थ्य सेवा प्रणालीको माध्यमबाट गुणस्तरीय स्वास्थ्य सेवामा सबैको पहुँच वृद्धि गरि प्रदेशवासीको स्वास्थ्य अवस्थामा उच्चतम सुधार ल्याउने।

### उद्देश्यहरू (Objectives)

१. सबै तहमा आवश्यक सेवा तथा पुर्वाधार, औषधी, औजार तथा उपकरण, सूचना, प्रविधि र दक्ष स्वास्थ्यकर्मीहरू सहितको सक्षम र प्रभावकारी स्वास्थ्य सेवा प्रणाली सुनिश्चित गर्नु।
२. आर्थिक, सामाजिक तथा भौगोलिक रूपमा पिछ्छिएका लगायत सबै प्रदेशवासीले सबै तहबाट सहज, सुलभ, सरल र गुणस्तरीय स्वास्थ्य सेवा प्राप्त गर्न सक्ने गरि सेवाको पहुँच अभिवृद्धि गर्नु।
३. स्वस्थ जीवनशैली प्रवर्द्धन, व्यवहार परिवर्तन र स्वास्थ्यमा प्रतिकूल असर गर्ने कारक तत्वहरूलाई निरुत्साहित गर्नका लागि अनुकूल वातावरण सिर्जना गर्नु।
४. आपतकालीन र विपद्को अवस्थामा स्वास्थ्य सेवा प्रवाहप्रभावकारी रूपमा अविच्छिन्न उपलब्ध गराउनु।
५. स्वास्थ्य सेवा व्यवस्थापनमा अन्तर सरकारी, सामुदायिक तथा बहुपक्षीय समन्वय, साभेदारी र सहकार्य गर्ने साथै आवश्यकता अनुरूप निजी र गैरसरकारी क्षेत्रसँग समेत सहकार्य गर्नु।
६. सुशासन, जवाफदेहिता र जिम्मेवारीपनको प्रवर्द्धन गरि स्वास्थ्य सेवालाई जनउत्तरदायी बनाउनु।
७. स्वास्थ्य क्षेत्रमा लगानी वृद्धि र समुचित प्रयोग गरि स्वास्थ्य समस्याका कारणले पर्ने व्यक्तिगत व्ययभारको अनुपात कम गर्नु।

**नीतिहरू**

प्रदेशको विशिष्टीकृत भौगोलिक तथा प्रादेशिक अवस्था तथा मौजुदा स्वास्थ्य सेवा सम्बन्धी समस्या र चुनौतिलाई सम्बोधन गर्दै प्रदेशका नागरिकहरूको सेवामा पहुँच तथा गुणस्तरीय स्वास्थ्य सेवा प्राप्त गर्ने अधिकार सुनिश्चित गर्न प्रदेश सरकारले देहायका नीति अवलम्बन गरेको छ ।

१. प्रदेशभित्रका सबै तहका स्वास्थ्य संस्थाबाट निःशुल्क, आधारभूत र आकस्मिक स्वास्थ्य सेवा सुनिश्चित गरिनेछ ।
२. विशेषज्ञ तथा विशिष्टीकृत स्वास्थ्य सेवालार्ई सुदृढीकरण गर्दै समतामूलक पहुँच वृद्धि गरिने छ ।
३. गुणस्तरीय स्वास्थ्य सेवा प्रवाहको लागि आवश्यक पूर्वाधार, औषधि, औषधिजन्य सामाग्री, औजार, उपकरण तथा निदानात्मक सेवाको व्यवस्था गरिने छ ।
४. स्वास्थ्य सेवा प्रवाहलाई सुदृढ गर्न दक्ष जनशक्ति उत्पादन, वितरण, परिचालन तथा व्यवस्थापन गरिने छ ।
५. आयुर्वेद तथा प्रदेशमा प्रचलित अन्य परम्परागत, प्राकृतिक चिकित्सा, योग लगायत वैकल्पिक चिकित्सा पद्धतिहरूको आधारभूत, विशेषज्ञ तथा विशिष्टीकृत स्वास्थ्य सेवा प्रभावकारी रूपमा उपलब्ध गराइने छ ।
६. न्यूनतम सेवा मापदण्ड (Minimum Service Standard) तथा राष्ट्रिय चिकित्सा मापदण्ड (National Medical Standard)का आधारमा प्रादेशिक मापदण्ड तयार गरि स्वास्थ्य संस्थाहरूबाट गुणस्तरीय रूपमा स्वास्थ्य सेवा प्रवाह गरिने छ ।
७. सामाजिक, आर्थिक, भौगोलिक, लैंगिक, धार्मिक र साँस्कृतिक हिसाबले पछाडि परेका समुदायको गुणस्तरीय स्वास्थ्य सेवामा पहुँच र उपयोगको वृद्धि गरिने छ ।
८. किशोर किशोरी तथा महिलाको सुरक्षित मातृत्व तथा प्रजनन स्वास्थ्य अधिकार सुनिश्चित गरिने छ ।
९. नसर्ने रोगहरूको रोकथाम तथा व्यवस्थापनको लागि प्रवर्धनात्मक, प्रतिकारात्मक, उपचारात्मक, पुनर्स्थापनात्मक तथा प्रशामक (Palliative) स्वास्थ्य सेवा प्रवाह गरिने छ ।
१०. स्वस्थ सकारात्मक व्यवहार परिवर्तनका लागि स्वास्थ्य शिक्षा र सूचना प्रवाह गर्दै अनुकूल वातावरण सुनिश्चित गरिने छ ।
११. बहूदो शहरीकरणबाट उत्पन्न हुने स्वास्थ्य समस्याहरूको व्यवस्थापनको लागि शहरी स्वास्थ्य प्रवर्द्धन योजना तर्जुमा गरि कार्यान्वयन गरिने छ ।
१२. स्वास्थ्यवर्धक खाद्यप्रदार्थको प्रवर्द्धन र उपभोग बढाई पोषण स्थितिमा सुधार गरिने छ र उत्पादन तथा पहुँचमा वृद्धि गर्न आवश्यक समन्वय गरिने छ ।
१३. विपद् वा प्रकोपको समयमा पर्ने सक्ने सम्भवत स्वास्थ्य असरहरू तथा महामारी न्यूनीकरण एवम प्रतिकार्यको लागि बहुपक्षीय सहकार्य गरिने छ ।
१४. वातावरणबाट स्वास्थ्यमा पर्ने प्रतिकूल असरहरू न्यूनीकरण तथा व्यवस्थापन गरिने छ ।
१५. स्वास्थ्य क्षेत्रका प्रगती एवम उपलब्धीहरूलाई संस्थागत गर्दै थप उपलब्धी हासिल गर्न आवश्यक समन्वय र सहकार्य गरिने छ ।
१६. विभिन्न कार्यस्थलहरूमा काम गर्ने कामदारहरूको पेशागत स्वास्थ्य सुरक्षा सुनिश्चित गरिने छ
१७. स्वास्थ्य सेवाको पहुँच र उपयोगमा वृद्धि गर्न सार्वजनिक, सामुदायिक तथा आवश्यकता अनुसार नीजी क्षेत्रसँग साभेदारी गरिने छ ।
१८. अध्ययन तथा अनुसन्धानात्मक कार्यलाई प्रवर्द्धन गर्दै निष्कर्षको आधारमा स्वास्थ्य कार्यक्रम तथा रणनीति निर्माण गरि लागु गरिने छ ।

१९. तथ्यमा आधारित योजना बनाउन र स्वास्थ्य सेवाको प्रभावकारी व्यवस्थापन गर्न एकीकृत स्वास्थ्य सूचना प्रणालीलाई थप सुदृढ र प्रविधिमैत्री बनाईने छ ।
२०. स्वास्थ्य क्षेत्रमा सुशासन कायम गर्दै स्वास्थ्य सेवालाई जनमुखी एवम् परिमाणमुखी बनाईने छ ।
२१. सरुवा रोग, किटजन्य रोग, पशुपन्छीजन्य रोग एवम् सिकल सेलएनेमिया, थालासेमिया जस्ता निश्चित स्थान र समुदायमा विद्यमान रोगहरु तथा खुला सिमानाबाट भित्रिन सक्ने रोगहरुको रोकथाम, नियन्त्रण तथा व्यवस्थापन प्रभावकारी रूपमा गरिने छ ।
२२. स्वास्थ्य क्षेत्रमा लगानी वृद्धि गर्दै सामाजिक सुरक्षा योजनालाई सुदृढ गरि स्वास्थ्य उपचारमा पर्ने व्यक्तिगत व्ययभार कम गरिने छ ।
२३. प्रदेशमा आउने र प्रदेशबाट बाहिर जाने व्यक्तिहरुको स्वास्थ्य सुरक्षालाई जोड दिँदै प्रदेश भित्र स्वास्थ्य पर्यटनको प्रबद्धन गरिने छ ।
२४. जनसांख्यिक स्थिति र वितरणको आधारमा स्वास्थ्य सेवा कार्यक्रम तर्जुमा गरि कार्यन्वयन गरिने छ ।

### ३। नेपालको संविधान २०७२ मा स्वास्थ्य:

नेपालको संविधान २०७२ मा स्वास्थ्य सम्बन्धी नागरिकका मौलिक हक र कर्तव्य निम्नानुसार रहेका छन् ।

#### धारा ३५. स्वास्थ्य सम्बन्धी हकहरु :

- (१) प्रत्येक नागरिकलाई राज्यबाट आधारभूत स्वास्थ्य सेवा निःशुल्क प्राप्त गर्ने हक हुनेछ र कसैलाई पनि आकस्मिक स्वास्थ्य सेवाबाट वञ्चित गरिने छैन ।
- (२) प्रत्येक व्यक्तिलाई आफ्नो स्वास्थ्य उपचारको सम्बन्धमा जानकारी पाउने हक हुनेछ ।
- (३) प्रत्येक नागरिकलाई स्वास्थ्य सेवामा समान पहुँचको हक हुनेछ ।
- (४) प्रत्येक नागरिकलाई स्वच्छ, खानेपानी तथा सरसफाइमा पहुँचको हक हुनेछ ।

#### यसका अतिरिक्त धारा ३८ को महिलालाई सुरक्षित मातृत्व र प्रजनन स्वास्थ्य सम्बन्धी हक हुनेछ ।" भन्ने कुरा उल्लेख छ ।

त्यस्तै धारा ५१ मा उल्लेखित राज्यकानीतिहरू अन्तर्गत स्वास्थ्य सम्बन्धी देहायका नीतिहरू राज्यले अवलम्बन गर्नेछः-

- (५) नागरिकलाई स्वस्थ बनाउन राज्यले जनस्वास्थ्यको क्षेत्रमा आवश्यक लगानी अभिवृद्धि गर्दै जाने,
- (६) गुणस्तरीय स्वास्थ्य सेवामा सबैको सहज, सुलभ र समान पहुँच सुनिश्चित गर्ने,
- (७) नेपालको परम्परागतचिकित्सा पद्धतिको रूपमा रहेको आयुर्वेदिक, प्राकृतिकचिकित्सा र होमियोपेथिकलगायत स्वास्थ्य पद्धतिको संरक्षण र प्रवर्धन गर्ने,
- (८) स्वास्थ्य क्षेत्रमा राज्यको लगानी अभिवृद्धि गर्दै यस क्षेत्रमाभएको निजी लगानीलाई नियमन र व्यवस्थापन गरी सेवामूलक बनाउने,
- (९) स्वास्थ्य सेवालाई सर्वसुलभ र गुणस्तरीय बनाउन स्वास्थ्य अनुसन्धानमा जोड दिँदै स्वास्थ्य संस्थार स्वास्थ्यकर्मीको संख्या वृद्धि गर्दै जाने,
- (१०) नेपालको क्षमता र आवश्यकताका आधारमा जनसंख्या व्यवस्थापनका लागि परिवार नियोजनलाई प्रोत्साहित गर्दै मातृशिशु मृत्युदर घटाई औसत आयु बढाउने ।

स्थानीय तहको स्वास्थ्य सम्बन्धि अधिकार तथा कार्य विस्तृतीकरण

संविधान, अनुसूची ८ (९) : आधारभूत स्वास्थ्य र सरसफाइ

अनुसूची	अधिकार सूचीको क्र. सं	संविधानको अधिकार सूचीकाविषयको विस्तृतीकरण
अनुसूची ८ (९) आधारभूत स्वास्थ्य र सरसफाइ	९.१	आधारभूत स्वास्थ्य र सरसफाइ सम्बन्धी नीति, कानून, मापदण्ड, योजना, कार्यान्वयन तथा नियमन
	९.२	आधारभूत स्वास्थ्य सेवा संचालन र प्रवर्द्धन
	९.३	अस्पताल र अन्य स्वास्थ्य संस्थाको स्थापना तथा सञ्चालन
	९.४	स्वास्थ्य सेवा सम्बन्धी भौतिक पूर्वाधार विकास तथा व्यवस्थापन
	९.५	स्वस्थ खानेपानी र खाद्यपदार्थको गुणस्तर एवं वायु तथा ध्वनि प्रदूषण नियन्त्रण
	९.६	सरसफाई सचेतना अभिवृद्धि र स्वास्थ्यजन्य फोहोर व्यवस्थापन
	९.७	स्वास्थ्यजन्य फोहरमैला संकलन, पुनर्उपयोग, प्रशोधन, विसर्जन, सेवा शुल्क निर्धारण र नियमन
	९.८	रक्त संचार सेवा, स्थानीय तथा शहरी स्वास्थ्य सेवा
	९.९	औषधीपसल सञ्चालन र नियमन

संविधान, अनुसूची ९ (३) : स्वास्थ्य

अनुसूची	अधिकार सूचीको क्र.सं	संविधानको अधिकार सूचीकाविषयको विस्तृतीकरण
अनुसूची ९(३) बाट स्वास्थ्य	३.१	राष्ट्रिय तथा प्रादेशिक लक्ष्य र मापदण्ड बमोजिम स्थानीय स्तरको लक्ष्य र गुणस्तर निर्धारण
	३.२	राष्ट्रिय र प्रादेशिक लक्ष्य र मापदण्ड अनुरूप जनरल अस्पताल र नर्सिङ होम, निदान केन्द्र र अन्य स्वास्थ्य संस्थाहरुको क्लिनिक दर्ता, सञ्चालन अनुमति र नियमन
	३.४	स्थानीयस्तरमा औषधीजन्य वनस्पति, जडिबुटी र अन्य औषधीजन्य वस्तुको उत्पादन, प्रशोधन र वितरण
	३.५	स्वास्थ्य विमा लगायतका सामाजिक सुरक्षा कार्यक्रम व्यवस्थापन
	३.६	स्थानीयस्तरमा औषधी तथा अन्य मेडिकल उत्पादनहरुको न्यूनतम मूल्य निर्धारण तथा नियमन
	३.७	स्थानीयस्तरमा औषधीको उचित प्रयोग र सूक्ष्म जीव निरोधक प्रतिरोध (Antimicrobial Resistance) न्यूनीकरण
	३.८	स्थानीयस्तरमा औषधी र स्वास्थ्य उपकरणको खरिद, भण्डारण र वितरण
	३.९	स्थानीयस्तरमा स्वास्थ्य सूचना प्रणाली व्यवस्थापन

## ४। राष्ट्रिय जनसंख्या नीति, २०७१

### राष्ट्रिय जनसंख्या नीतिको भावी सोच, ध्येय, लक्ष्य तथा उद्देश्यहरु :

राष्ट्रिय जनसंख्यानीतिको भावी सोच, ध्येय, लक्ष्य तथा उद्देश्यहरु देहायबमोजिम रहेका छन् :

#### भावी सोच (Vision)

हरेक नागरिकलाई गुणस्तरीय जीवनयापन गर्ने अवसरको वृद्धि भएको हुनेछ ।

#### ध्येय (Mission)

जनसंख्या, वातावरण र विकास बीच सामञ्जस्य कायम गरी नागरिकलाई अधिकारमा आधारित जनसंख्या र विकासका एकीकृत सेवाप्रवाहको सुनिश्चितता गर्दै उत्पादनशील र स्तरीय जीवनयापनको वातावरण बनाउने ।

#### लक्ष्य (Goal)

- १। जनसंख्याका सवालहरुलाई विकाससँग एकीकरण गर्दै सबै नागरिकको जीवनमा गुणस्तरीय सुधार ल्याउने, प्रजनन स्वास्थ्य तथा प्रजनन सम्बन्धी मौलिक अधिकारलाई सुनिश्चित गर्ने र जनसंख्या व्यवस्थापनमा लैगिक समानता तथा सामाजिक समावेशीकरणलाई प्रवर्धन गर्नु यस नीतिको लक्ष्य रहेको छ ।
- २। सहश्राब्दी विकास लक्ष्य तथा दिगो विकास लक्ष्य समेतलाई ध्यानमा राखी यो नीति कार्यान्वयनमा आएपछि बीस वर्ष (वि.सं. २०९० वा सन् २०३४) भित्रमा नेपालले हासिल गर्न सक्ने लक्ष्य देहायानुसार निर्धारण गरिएको छ ।

### जनसंख्या सम्बन्धी सूचकहरुको आगामी २० वर्षका लक्ष्य

क्र.सं.	सूचकहरु	लक्षितवर्ष वि.सं.(२०३४) (सन् २०९०)
१	कुल प्रजनन् दर (TFR), प्रति महिला	2.1
२	वार्षिक जनसंख्या वृद्धिदर, प्रतिशत	1.1
३	कोरा मृत्युदर (CDR), प्रति हजार	5.0
४	शिशु मृत्युदर (IMR), प्रति हजार जीवित जन्म	25.0
५	औसत आयु (वर्ष) दुवै लिङ्ग	75.0
	पुरुष	74.0
	महिला	76.0
६	घरपरिवारको औसत आकार	4.1
७	अनुपस्थित जनसंख्या, प्रतिशत	5.0
८	साक्षरता प्रतिशत (दस वर्षमाथिको जनसंख्या)	95.0
९	परिवार नियोजन साधनमा पहुँच हुने सम्भाव्य दम्पती प्रतिशत	90.0
१०	सहरी जनसंख्या, प्रतिशत	60.0

## ५. सोहो योजना (आर्थिक वर्ष: २०८१/८२-२०८५/८६)

### स्वस्थ, शिक्षित र सीपयुक्त मानव पुँजी निर्माण

मानव पुँजीले आर्थिक सामाजिक रूपान्तरण र आर्थिक विकासमा बहुआयामिक योगदान प्रदान गर्दछ। सामूहिक ज्ञान, सीप र क्षमता तथा स्वस्थ जनशक्तिबाट मानव पुँजी निर्माण हुन्छ। स्वास्थ्य, शिक्षा र खेलकुद क्षेत्रमा गरिने लगानीले आर्थिक वृद्धि र सामाजिक कल्याणलाई बढावा दिन्छ। नेपालको संविधानले मौलिक हक तथा राज्यका नीतिहरू मार्फत स्वास्थ्य, शिक्षा तथा मानव जीवनका समग्र पक्षलाई समेटेको मानव पुँजी निर्माणका लागि मार्गदर्शन गरेको छ।

स्वास्थ्यले मानवको जीवनभर उत्पादकत्व र श्रम शक्ति सहभागितालाई प्रभाव पार्छ। मानव पुँजी निर्माणको चक्रले वर्तमान पुस्ता मात्र नभई भावी पुस्ताका लागि पनि बलियो आधार तयार गर्दछ। स्वस्थ आमाबाबुले बच्चाहरूको लागि पोषण र स्वस्थ वातावरण प्रदान गर्दछन्। जनसङ्ख्याको स्वास्थ्य स्थितिले दीर्घकालीन आर्थिक समृद्धि र सामाजिक-आर्थिक रूपान्तरणमा महत्वपूर्ण योगदान दिन्छ। यस सन्दर्भमा सर्वसुलभ तथा गुणस्तरीय स्वास्थ्य सेवासहितको प्रणाली सुनिश्चित गर्नु आवश्यक छ।

राष्ट्रिय जनगणना २०७८ अनुसार देशको कुल जनसङ्ख्याको ६७ प्रतिशत जनसङ्ख्या उत्पादनशील उमेर समूहमा परेकोले सोको जनसङ्ख्यात्मक लाभ लिने गरी आवश्यक मानव पुँजी निर्माण गर्न थप लगानी गर्नुपर्ने अवस्था छ। मानव पुँजी निर्माणमा संघ, प्रदेश र स्थानीय तहको भूमिका र जिम्मेवारीलाई प्रभावकारी रूपमा निर्वाह गर्न समन्वय र साभेदारीलाई महत्व प्रदान गरिएको छ।

### मुख्य सवाल तथा चुनौती

- (१) भौतिक पूर्वाधार, प्रविधि तथा सामग्रीको व्यवस्थापन
- (२) देशको विभिन्न क्षेत्रमा आवश्यक पर्ने दक्ष जनशक्तिको उत्पादन र आपूर्ति सुनिश्चितता
- (३) समतामूलक र समावेशी व्यवस्थापन तथा पहुँच सुनिश्चितता
- (४) तहगत तथा क्षेत्रगत समन्वय र नियमनको प्रभावकारिता अभिवृद्धि
- (५) विज्ञान प्रविधिको अधिकतम प्रयोग गरी सेवाप्रदायक संस्थाहरूको प्रभावकारिता अभिवृद्धि
- (६) स्वास्थ्य बीमाको प्रभावकारिता अभिवृद्धि
- (७) मानव पुँजी निर्माणमा संलग्न सेवा प्रदायकको दक्षता अभिवृद्धि
- (८) महामारी र विपद्लाई उचित व्यवस्थापन गर्न प्रदेश स्तरसम्म स्थायी संयन्त्रको विकास

### रूपान्तरणकारी रणनीति : स्वास्थ्य तथा जनसङ्ख्या

- (१) आधारभूत स्वास्थ्य सेवा निःशुल्क प्रदान गर्ने
- (२) गुणस्तरीय स्वास्थ्य सेवामा सर्वव्यापी पहुँच सुनिश्चित गर्नु
- (३) स्वास्थ्य बीमा प्रणालीलाई पुनःसंरचना गरी सबल बनाउने
- (४) समग्र स्वास्थ्य प्रणालीको अत्याधुनिक र उच्चतम प्राविधिकरण गर्ने
- (५) गुणस्तरीय, भरपर्दो, तथा एकीकृत स्वास्थ्य प्रणालीको विकास गर्ने

- (६) स्वास्थ्य पर्यटन प्रवर्द्धन गर्ने
- (७) बहुक्षेत्रीय र बहुपक्षीय अवधारणा अवलम्बन गर्ने
- (८) जनसाङ्ख्यिक लाभांशको अधिकतम उपयोग गर्ने
- (९) अध्ययन, अनुसन्धान तथा तथ्यमा आधारित स्वास्थ्य्य वस्थापन प्रणालीको विकास गर्ने
- (१०) औषधि, औषधिजन्य सामग्री र खोपको उत्पादनमा आत्मनिर्भर हुने
- (११) स्वास्थ्य क्षेत्रमा सुशासन तथा सामाजिक न्याय कायम गर्ने
- (१२) स्वास्थ्य प्रणालीको सुदृढीकरणका लागि लगानी अभिवृद्धि गर्ने
- (१३) विद्यमान सञ्चालनमा रहेका कार्यक्रमहरू पुनःमूल्याङ्कन र परिमार्जन गर्ने

**प्रमुख कार्यक्रम: स्वास्थ्य तथा जनसङ्ख्या**

- (१) स्वास्थ्य क्षेत्रमा लगानी अभिवृद्धि कार्यक्रम
- (२) आधारभूत र सामुदायिक स्वास्थ्य सेवा सुदृढीकरण कार्यक्रम
- (३) स्वास्थ्य बीमा तथा सामाजिक स्वास्थ्य सुरक्षाको एकीकृत कार्यक्रम
- (४) स्वास्थ्य सेवा एवम् प्रदायक सस्थाहरूको गुणस्तर अभिवृद्धि गर्ने कार्यक्रम
- (५) सघन स्वास्थ्य क्षेत्र मानव संसाधन प्रणाली विकास तथा सञ्चालन कार्यक्रम
- (६) स्वास्थ्य क्षेत्र डिजिटलाईजेशन कार्यक्रम
- (७) विशिष्टकृत सेवा अस्पताल सञ्चालन कार्यक्रम
- (८) स्वास्थ्य क्षेत्र एकीकृत व्यवस्थापन सूचना प्रणाली कार्यक्रम
- (९) बहुक्षेत्रीय तथा बहुपक्षीय संयन्त्र मार्फत स्वास्थ्य सेवा प्रवाह कार्यक्रम
- (१०) बहुक्षेत्रीय पोषण कार्यक्रम
- (११) किटजन्य, सर्ने तथा नसर्ने र उन्मूलनको नजिक रहेका रोगहरूको नियन्त्रण तथा रोकथाम कार्यक्रम
- (१२) सुरक्षित मातृत्व तथा प्रजनन स्वास्थ्य कार्यक्रम
- (१३) जलवायु परिवर्तन उत्थानशील स्वास्थ्य कार्यक्रम
- (१४) जनस्वास्थ्य प्रयोगशाला सुदृढीकरण कार्यक्रम
- (१५) मानसिक तथा वैकल्पिक स्वास्थ्यसम्बन्धी कार्यक्रम
- (१६) अध्ययन अनुसन्धानमा आधारित स्वास्थ्य तथा जनसङ्ख्या व्यवस्थापन प्रणाली
- (१७) समतामूलक तथा समावेशी स्वास्थ्य कार्यक्रम
- (१८) सरकारी, सामुदायिक तथा निजी क्षेत्रबाट सञ्चालित स्वास्थ्य सेवा कार्यक्रमको नियमन तथा व्यवस्थापन कार्यक्रम
- (१९) औषधि र औषधिजन्य सामग्री उत्पादन तथा व्यवस्थापन कार्यक्रम
- (२०) अन्तर्राष्ट्रिय स्वास्थ्य पर्यटन प्रवर्द्धन कार्यक्रम

**परिमाणात्मक लक्ष्य**

क्र.सं.	सूचक	एकाइ	आ.व. २०७९/८०	आ.व. २०८५/८६
<b>(क)स्वास्थ्य</b>				
१	मातृमृत्यु दर (प्रति लाख जीवित जन्ममा)	जना	१५१	८५
२	नवजात शिशु मृत्यु दर (प्रति हजार जीवित जन्म)	जना	२१	१३
३	पाँच वर्षमुनिका बालबालिकाको मृत्यु दर (प्रति हजार जीवित जन्ममा)	जना	३३	२२
४	पाँच वर्षमुनिका बालबालिकाको पुङ्कोपनाको अवस्था	प्रतिशत	२५	१७
५	सडक दुर्घटनाका कारण ज्यान गुमाउने व्यक्तिको सङ्ख्या (प्रति एकलाख जनसङ्ख्यामा)	जना	९.५	५
६	पूर्ण खोपपाउने बालबालिका	प्रतिशत	८०	९५
७	स्वास्थ्यकर्मी उत्पादन (प्रति हजार जनसङ्ख्यामा)	जना	१.९४	४.६४
८	स्वास्थ्य बीमामा आवद्द जनसङ्ख्या	प्रतिशत	२१	७०
९	स्वास्थ्य बीमामा कार्यक्रममा नवीकरण दर	प्रतिशत	६९	९०
१०	कुल स्वास्थ्य खर्चमा व्यक्तिगत तहमा हुने खर्च	प्रतिशत	५४.२	३८
११	३० मिनेटको दुरीमा स्वास्थ्य संस्था भएका घरधुरी	प्रतिशत	७७	८६
१२	पाँच वर्षमुनिका बच्चाहरू मध्ये जन्म दर्ता गरिएको बालबालिका	प्रतिशत	७४	१००

### 1.2.1 Sustainable Development Goals

The Sustainable Development Goals (SDGs), officially known as Transforming our world: the 2030 Agenda for Sustainable Development, are a set of seventeen aspirational "Global Goals" with 169 targets. SDG 3, titled "Good Health and Well-being," has 13 targets and 28 indicators used to measure progress toward these targets. These targets cover a wide range of health-related goals, including reducing maternal mortality, ending preventable deaths of newborns and children under five, combating epidemics, reducing mortality from non-communicable diseases, promoting mental health, and achieving universal health coverage. It is a direct result of the fact that Goal 3 can build on experiences with the Millennium Development Goals (MDGs), which had a direct focus on health (MDGs 4, 5, and 6). In this regard, in particular, it is unfortunate that some of the main lessons learnt from the MDGs have not been accounted for. Clear examples are Targets 3.1, 3.4, and 3.6, which focus on global reductions only. Global targets not only risk masking significant variations in the starting conditions of countries but also risk being adopted at the national level, as experience with the MDGs has demonstrated. The Inter-Agency and Expert Group (IAEG) on SDG Indicators suggests repeatedly disaggregating data by geographic location (e.g., urban and rural) but also by age group, sex, and income as data systems improve.

**Targets:**

**Target 3.1:** The target requires that by 2030 to "reduce the global maternal mortality ratio to less than 70 per 100,000 live births"

**Target 3.2:** The target requires that by 2030 to "end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births".

**Target 3.3:** The target requires by 2030 to "end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases, and other communicable diseases".

**Target 3.4:** The target requires by 2030 to "reduce by one-third pre-mature mortality from non-communicable diseases (NCDs) through prevention and treatment, and promote mental health and wellbeing"

**Target 3.5:** The target requires "strengthening prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol".

**Target 3.6:** The target requires that by 2020 to "halve global deaths and injuries from road traffic accidents"

**Target 3.7:** The target requires that by 2030 to "ensure universal access to sexual and reproductive health care services"

**Target 3.8:** The target requires "achieve universal health coverage (UHC), including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all".

**Target 3.9:** The target requires that by 2030 to "substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water, and soil pollution and contamination".

From the above targets, we can conclude that the goal's focus is on healthy lives and well-being, instead of the mere absence of disease or infirmity, which is not sufficiently reflected in its operationalization. This could be mended if targets 3.3 and 3.4, with their focus on specific communicable and non-communicable diseases, were to be measured by changes in the Health Adjusted Life Expectancy (HALE) indicator. The targets for the goal are, in general, precise in their formulation with a rather high level of ambition. Targets 3.1, 3.4, and 3.6, however, focus on global reductions only. Whereas the experience with the MDGs demonstrated that the compelling advantages of country comparisons contributed to the adoption of global goals at the national level, the 2030 Agenda foresees the requirements for national implementation plans that will reflect national circumstances and will prevent these targets from unfairly impacting those countries with bad starting conditions. We welcome the inclusion of Target 3.9, but anticipate the huge challenge of translating this target into a meaningful indicator. Finally, almost all means of implementation explicitly refer to developing countries only, which goes against the aspired universal character of the 2030 Agenda. But, of course, it also highlights the need for poor countries to receive external support.

## 1.2.4 National Population Policy 2082 B.S.

### Introduction

The Constitution of Nepal has embraced a federal governance system and mentions that the population should be based on a community of capable citizens dedicated to national interests, ensuring social justice, inclusivity, equality, and the construction of an egalitarian society, as well as the protection of the fundamental rights and interests of all citizens. Under the policies adopted by the state, the Constitution emphasizes making citizens capable and willing to serve the nation according to national needs; appropriately utilizing the knowledge, skills, and experience of former civil servants for the benefit of the nation; updating demographic statistics and linking them to national development plans; and enhancing youth participation in national development.

Previous periodic plans have recognized the issue of population as an important aspect of development, focusing on human capital development, social justice, inclusivity, rural development, organized urbanization, balanced distribution of the population, balanced development, effective management of demographic dynamics, and the optimal utilization of demographic benefits.

The Sixteenth Plan prioritizes issues such as creating healthy, educated, and skilled human capital, gender equality, social justice, and population management based on an inclusive society, while also emphasizing the integration of the knowledge, skills, and experience of senior citizens with production, management of internal migration, organized urbanization, and the utilization of demographic benefits.

Nepal's long-term population plan (2067-87), Sustainable Development Goals, 2030 Population Policy, 2071, and National Gender Equality Policy, 2077 emphasize the multidimensionality of population by integrating it into all aspects of development for sustainable development and utilization, strengthening the human development system for quality population, and establishing capable institutional arrangements for population management, among other issues. The Government of Nepal has committed to giving high priority to population in the national planning system by mobilizing financial resources based on reproductive health, focusing on population-based development systems, and has participated in various conferences, including the International Conference on Population and Development (ICPD) held in Cairo in 1994 and the Beijing Conference in 1995.

Despite the aforementioned policy arrangements, the results of the National Census 2078 show an average annual population growth rate of 0.92 percent over the last ten years, a total fertility rate of 1.94 per woman (compared to 2.6 in the 2068 census), and a negative population growth rate in 34 districts and 319 local levels, including all districts in the Himalayas. The number of children under 15 has decreased from 34.9 percent to 27.8 percent, while the population aged 60 and above stands at 10.21 percent (compared to 8.1 percent in the 2068 census). The neonatal mortality rate is 21 per thousand live births, the infant mortality rate is 28 per thousand live births, the child mortality rate is 33 per thousand live births, and the maternal mortality ratio is 151 per hundred thousand live births. The sex ratio at birth is 112:100, and the absent (overseas) population is 7.5 percent, with the demographic dividend (population aged 15 to 59 years) being 61.9 percent.

Looking at the statistical situation, there is a continuous decline in the birth rate, an increase in average life expectancy, a decrease in the number of children, an increase in the number of senior citizens, behavioral changes related to reproduction among the youth, a growing attraction of the youth towards foreign employment and educational migration, as well as disorganized internal migration and urbanization, and increasing urban poverty. In the context of the fertility rate being below the replacement level and the declining population growth rate, it seems necessary to address this issue and prepare an environment for the effective utilization of demographic dividends in the future.

**Vision:** Capable human capital for the social, economic, and cultural transformation of the country.

**Mission:** To establish a balance between population and sustainable development through the management of demographic resources and dynamics.

**Goals**

- (a) To achieve social and economic prosperity in the country by developing healthy, educated, entrepreneurial, and productive human capital.
- (b) To contribute to sustainable development by achieving the developmental impact of the population and to build a healthy and culturally rich society based on social justice, equality, and inclusion.
- (c) Specific, measurable, and time-bound quantitative targets will be set to achieve the vision and goals of the policy.

**Targets:**

S.N.	List of major measurable indicators	Unit	Fiscal Year 2079/80 (2022 A.D.)	Target Year 2086/87 (2030 A.D.)
1.	Reproductive rate of adolescents aged 15 to 19 (per 1,000 live births)	Number	63	30
2.	Life expectancy (at birth)	Years	71.3	75
3.	Maternal mortality ratio (per 100,000 live births)	Number	151	70
4.	Under-five mortality rate (per 1,000 live births)	Number	33	20
5.	Neonatal mortality rate (per 1,000 live births)	Number	21	12
6.	Malnourished population	Percentage	20.6	3
7.	Family planning needs are met by modern methods / techniques / devices for women of reproductive age (aged 15 to 49)	Percentage	74	50
8.	Total literacy rate	Percentage	76.3	99
	Female		69.4	99
	Male		83.6	99
9.	Per capita income	US Dollar	1456	2500
10.	Under five children are having birth registration	Percentage	74	95
11.	Population covered by health insurance	Percentage	21	100
12.	Gender Development Index	Index	0.885	0.90
13.	Gender Inequality Index	Index	0.29	0.05
14.	Gender Empowerment Measure Index	Index	0.63	0.69
15.	Human Development Index	Index	0.601	0.70
16.	Senior citizen day care and meeting centers	Local	225	753

## 1.2.7 Health Policy of Lumbini Province

### Introduction

The Constitution of Nepal has established free basic and emergency health services as a fundamental right. With the country having transformed into a federal governance system, the structure and service system of health services have been divided into three tiers: federal, provincial, and local. The provinces also have the responsibility to ensure universal access to quality health services within the federal structure. Following the Constitution, the priorities of the provincial health policy have been determined by analyzing the rights list of various levels of work, federal policies and programs, sustainable development goals, international commitments made by Nepal at different times, problems and challenges within the health sector in the province, provincial policies, available resources and means, as well as facts and evidence. Based on this, the Provincial Health Policy, 2077 B.S., has been formulated and issued to realize the long-term vision of a prosperous province with happy citizens for the prosperity of the province.

**Vision:** Healthy and happy citizens for a prosperous province.

**Mission:** Ensuring the fundamental right of provincial residents to live healthily.

**Goal:** To enhance access to quality health services through an equitable and robust health service system, thereby bringing about the highest improvement in the health status of provincial residents.

### Objectives

1. Ensure a capable and effective health service system at all levels, including essential services and infrastructure, medicines, tools and equipment, information, technology, and skilled health workers.
2. Increase access to services so that all residents of the provinces, including those who are economically, socially, and geographically disadvantaged, can receive health services that are easy, accessible, simple, and of high quality.
3. Create a conducive environment to promote healthy lifestyles, change behaviors, and discourage factors that adversely affect health.
4. Provide uninterrupted health services effectively during emergencies and disaster situations.
5. Coordinate, partner, and collaborate among government, community, and multilateral organizations in health service management, as well as cooperate with the private and non-governmental sectors as needed.
6. Make health services accountable to the public by promoting good governance, accountability, and responsibility.
7. Increase investment in the health sector and utilize it appropriately to reduce the proportion of personal financial burden caused by health issues.

### **Policies**

Addressing the specific geographical and regional conditions of the province and the existing problems and challenges related to health services, the provincial government has adopted the following policies to ensure the right of citizens to access services and receive quality health care.

1. Free, basic, and emergency health services will be ensured from all levels of health institutions within the province.
2. The strengthening of specialized and specialized health services will increase equitable access.
3. Necessary infrastructure, medicines, medicinal supplies, tools, equipment, and diagnostic services will be arranged for the flow of quality health services.
4. Skilled human resources will be produced, distributed, operated, and managed to strengthen the health service flow.
5. Basic, specialized, and expert health services of Ayurveda and other traditional, natural medicine practices prevalent in the province, including yoga and alternative medicine systems, will be effectively made available.
6. Based on the Minimum Service Standard and National Medical Standard, regional standards will be prepared, and quality health services will be provided by health institutions.
7. Access to and utilization of quality health services for socially, economically, geographically, gender-wise, religiously, and culturally marginalized communities will be increased.
8. The rights of adolescents, youth, and women to safe motherhood and reproductive health will be ensured.
9. Promotional, preventive, therapeutic, rehabilitative, and palliative health services will be provided for the prevention and management of non-communicable diseases.
10. Health education and information flow will be ensured to create a conducive environment for healthy, positive behavior change.
11. An urban health promotion plan will be formulated and implemented to manage health problems arising from increasing urbanization.
12. The promotion and consumption of health-enhancing food products will be increased to improve nutritional status, and necessary coordination will be made to increase production and access.
13. Multilateral cooperation will be undertaken to address potential health impacts during disasters or emergencies and for pandemic mitigation and response.
14. Adverse health impacts from the environment will be reduced and managed.
15. Coordination and collaboration will be necessary to institutionalize the progress and achievements in the health sector to attain further accomplishments.
16. Occupational health and safety of workers in various workplaces will be ensured.
17. Partnerships will be established with the public, community, and private sectors as needed to increase access to and utilization of health services.

18. By promoting studies and research work, health programs and strategies will be developed and implemented based on the findings.
19. An integrated health information system will be further strengthened and made technology-friendly to create evidence-based plans and effectively manage health services.
20. Good governance in the health sector will be established to make health services people-centered and results-oriented.
21. Effective prevention, control, and management of communicable diseases, vector-borne diseases, zoonotic diseases, and certain diseases like sickle cell anemia and thalassemia prevalent in specific areas and communities, as well as diseases that may enter through open borders, will be carried out.
22. By increasing investment in the health sector and strengthening social security plans, the individual financial burden on health care will be reduced.
23. Emphasizing the health safety of individuals coming into and going out of the province, health tourism will be promoted within the province.
24. Health service programs will be formulated and implemented based on demographic status and distribution.

## **1.2.8. Second Five-Year Plan (2081/82-2085/86 B.S.) of Lumbini Province**

### **1.2.8.1 Health**

#### **Introduction**

Healthy living is an important aspect of human development. Health is taken as a key indicator in the Human Development Index. The Constitution of Nepal includes the right to health under fundamental rights, ensuring that every citizen receives basic health services free of charge from the state, has equal access to health services, and is not deprived of emergency health services. The provincial government has exclusive authority over health services, while the shared authority between the federation and the province includes provisions for medicine, family planning, population management, medical services, Ayurvedic medicine, and Amchi. Additionally, health is mentioned under the shared authority of the three tiers of government. The Sustainable Development Goals aim to ensure the health of individuals of all age groups and promote prosperous living. Thus, the state is also mandated by the Constitution to ensure that everyone has easy, accessible, and equal access to quality health services to guarantee a healthy life. Various policies, laws, and plans have been formulated by the provincial government to organize health services. By the fiscal year 2080/81, this province has 3 federal hospitals, 14 provincial hospitals, 19 basic hospitals, 28 primary health centers, 563 health posts, 46 Ayurvedic dispensaries, 13 Ayurvedic health centers, 449 birthing centers, 2,965 vaccination clinics, 1,940 village clinics, 167 community health units, and 304 basic health centers.

**Long-term Vision:** A Prosperous Province with Healthy Human Capital

**Goal:** To ensure equitable and quality access to health services through a robust health system, promoting the health and well-being of provincial residents.

**Objectives:**

- (1) To develop an effective health system that increases equitable access to quality health services.
- (2) To establish good governance in the health sector, promoting a healthy lifestyle and reducing the individual financial burden for accessing services.
- (3) To ensure uninterrupted health services and enhance quality even during disasters and emergencies through multilateral cooperation.
- (4) To promote health through interrelated sectoral policies addressing the determinants of health through multi-sectoral collaboration.

**Strategy and Working Policies**

<b>Strategy</b>	<b>Working Policies</b>
<p>Strategy 1: Policy and Institutional Reform in Health at the Province</p>	<p>(1) Health institutions under the province will be mapped for service expansion and upgrading to ensure that the public receives quality health services close to them.</p> <p>(2) A framework will be implemented to provide easy, accessible, and quality services by establishing minimum service standards in all health institutions in the province.</p> <p>(3) An integrated information system will be organized in health institutions for effective regulation of services provided by private, community, cooperative, and non-profit health institutions.</p> <p>(4) The capacity of health workers employed in government, community, and private health institutions will be enhanced.</p> <p>(5) Through citizen-friendly policies, equitable access to health services will be increased for the poor, helpless, disabled, and sexual and gender minorities.</p> <p>(6) Based on needs, timely policies will be developed for the strengthening and reinforcement of the health system.</p> <p>(7) Policies and strategies related to the mental health of children and adolescents will be prepared.</p>
<p>Strategy 2: Development and Improvement of Health Infrastructure at the Provincial Level</p>	<p>(1) Health infrastructure under the province will be developed progressively.</p> <p>(2) The management of modern technological tools and equipment will be arranged to improve the quality of services provided by health institutions in the province.</p> <p>(3) Annual testing of tools and equipment will be conducted, and a record of regular maintenance and necessary repairs will be maintained with institutional human resource management.</p> <p>(4) To enhance the effective operation of ambulances, the existing GPS will be upgraded, and a system of connectivity between hospitals, ambulances, and service recipients will be strengthened.</p>

<b>Strategy</b>	<b>Working Policies</b>
<p>Strategy 3: Managing skilled human resources in health institutions.</p>	<p>(1) An organization and management survey of health institutions under the province will be conducted to deploy necessary human resources in health institutions.</p> <p>(2) The projection and management of health workers will be based on demographic and disease burden data.</p> <p>(3) The system for career development and encouragement of human resources will be strengthened.</p> <p>(4) A system will be developed to study and inform about new developments in the health sector (treatment methods, technologies, diseases, etc.).</p> <p>(5) An environment will be created for the production and development of skilled human resources in the province.</p>
<p>Strategy 4: Increase the effectiveness of health service delivery in the province.</p>	<p>(1) Services provided by provincial institutions will be made faster, more efficient, and of higher quality.</p> <p>(2) Necessary infrastructure for service users, including clean toilets, safe drinking water, and waiting areas for patients, will be arranged along with regular maintenance.</p> <p>(3) Proper management of cleanliness and hospital waste in health institutions will be ensured.</p> <p>(4) Facilitation will be provided to make health services offered by local governments effective and of high quality.</p> <p>(5) Local governments, districts, and provinces will be declared with full institutional maternity services upon meeting the established standards.</p> <p>(6) Arrangements will be made to provide services even in remote areas through medical colleges and private health institutions.</p>

<b>Strategy</b>	<b>Working Policies</b>
<p>Strategy 5: Providing quality and specialized health services.</p>	<p>(1) Specialized hospitals will be upgraded based on patient load to expand services.</p> <p>(2) Arrangements will be made for organized wards for palliative patients in hospitals.</p> <p>(3) The expansion of blood bank services and arrangements for providing free blood will be organized.</p> <p>(4) Dialysis services will be expanded based on the patient load of kidney patients.</p> <p>(5) The construction of trauma centers in Nepalgunj, Lamahi, and Bardghat will be completed to provide services.</p> <p>(6) Specialized service expansion will identify and utilize the potential for health treatment tourism (medical tourism).</p> <p>(7) Screening for non-communicable diseases and mental health issues will bring patients into the treatment framework.</p>
<p>Strategy 6: Promoting alternative and Ayurvedic health treatment methods.</p>	<p>(1) Promotion of yoga, meditation, and natural healing methods will be undertaken.</p> <p>(2) Structural strengthening will be carried out for the effective implementation of the Ayurvedic system.</p> <p>(3) Regulation and facilitation will be provided to promote the production of quality Ayurvedic medicines.</p> <p>(4) Facilitation will be provided for the availability of necessary raw materials for the Ayurvedic medicine production centers established in the province.</p> <p>(5) Management and transmission of knowledge related to locally available herbs and their traditional uses will be conducted.</p> <p>(6) Protection, development, and expansion of homeopathy, Unani, natural healing systems, and other complementary medical systems will be undertaken.</p>

<b>Strategy</b>	<b>Working Policies</b>
<p>Strategy 7: Reducing the personal financial burden in health services.</p>	<p>(1) Ensuring the quality of medicines distributed free of charge and arranging for regular supply.</p> <p>(2) Making the system of providing services through the impoverished citizens' fund effective to prevent situations where health treatment is not accessible due to a lack of financial resources.</p> <p>(3) Increasing access to the targeted community's health insurance program, creating an environment to benefit from insurance, and promoting insurance services.</p> <p>(4) Mapping areas affected by sickle cell anemia, thalassemia, hemophilia, and similar diseases in the province, providing free testing, treatment, and awareness-raising.</p> <p>(5) Providing necessary support for the treatment of impoverished citizens suffering from fatal diseases.</p> <p>(6) Operating pharmacies in hospitals with a high influx of patients in the province.</p> <p>(7) Continuing to provide free ambulance services for pregnant and postpartum women during referrals, and ensuring free air rescue for pregnant and postpartum women at risk in remote areas.</p> <p>(8) Arranging for free treatment of injured individuals from road accidents in the province by establishing an accident treatment fund and providing services from designated hospitals.</p>
<p>Strategy 8: Control of communicable diseases and epidemics and provision of emergency health services.</p>	<p>(1) Arrangements will be made to provide uninterrupted essential health services in disasters and emergencies.</p> <p>(2) The provincial health emergency operation center will be empowered to formulate preparedness plans and manage responses for the treatment of epidemics and communicable diseases.</p> <p>(3) Technical personnel and volunteers will be identified and registered for capacity development to control neglected tropical diseases, including epidemics and communicable diseases.</p>

<b>Strategy</b>	<b>Working Policies</b>
	<p>(4) Services will be provided considering the specific needs and sensitivities of the targeted community during the control of communicable diseases and epidemics.</p> <p>(5) Regular awareness campaigns will be conducted through various media regarding measures to prevent epidemics and communicable diseases.</p>
<p>Strategy 9: Adopting promotional and preventive health systems to prevent and control non-communicable diseases.</p>	<p>(1) Health awareness campaigns will be conducted through various means regarding the necessary mental state, diet, sleep, hygiene, and physical activity required for staying healthy.</p> <p>(2) Programs for public awareness, regulation, and control will be conducted to reduce smoking and the use of tobacco products, alcohol consumption, drug use, and the consumption of unhealthy food.</p> <p>(3) Collaboration with other stakeholders will be established to promote the consumption of clean and nutritious food, which is a major foundation of good health.</p> <p>(4) Programs will be conducted in collaboration with stakeholders to enhance public awareness and control and regulate factors affecting human health, such as environmental pollution, pesticide and toxin control, and antibiotic resistance.</p>
<p>Strategy 10: To regulate and facilitate public health services and health supply management.</p>	<p>(1) Coordination and support will be provided to local health institutions for the storage and distribution of vaccines, essential and emergency medicines, and health materials.</p> <p>(2) Facilitation and coordination will be provided at local levels for public health and vector surveillance, and disaster pandemic management.</p> <p>(3) Integration, analysis, study, and planning of health information will be carried out.</p> <p>(4) Supervision, monitoring, regulation, and quality assurance of health institutions operated by public, private, cooperative, and community sectors will be ensured.</p>

<b>Strategy</b>	<b>Working Policies</b>
	<p>(5) Implementation, coordination, and facilitation of special programs such as disease control, family planning, maternal/child health, specialist health camps, nutrition, and vaccination will be conducted.</p> <p>(6) Environmental health, drinking water and sanitation, and occupational health promotion and management will be carried out.</p> <p>(7) Nutritional food, vaccination, and sanitation-related information will be provided to children, postpartum women, and pregnant women.</p> <p>(8) Activities related to population management will be conducted.</p>
<p>Strategy 11: Strengthening coordination, cooperation, and interrelationships.</p>	<p>(1) Coordination will be established among the federation, local levels, and health-related bodies.</p> <p>(2) Inter-ministerial policy coordination and cooperation will be conducted to reduce determinants affecting health.</p> <p>(3) Hospital development committees and health-related organizations will be made capable, accountable, and effective.</p> <p>(4) Non-profit and philanthropic organizations providing health services will be encouraged, and management committees will be arranged to ensure representation of the relevant level of government for effective coordination.</p> <p>(5) An environment will be created for the exchange of health information and emergency assistance by establishing coordination and interrelationships with relevant bodies of the federal government and neighboring provinces.</p> <p>(6) Coordination and cooperation with health partner organizations will be strengthened.</p> <p>(7) A mechanism will be established to address the needs of disaster-affected populations, making it accountable to the affected population.</p>

**Health-Related Quantitative Targets**

S.N.	Indicators	Unit	Status of Fiscal Year 2080/81 B.S.	Target for Fiscal Year 2085/86 B.S.
1.	Life Expectancy	Years	69.5	73
2.	Population reaching health institutions within 30 minutes or less	Percentage	78	100
3.	Maternal Mortality Rate (per 100,000 live births)	Number	207	50
4.	Child Mortality Rate (per 1,000 live births under 5 years)	Number	41	22
5.	Out-of-pocket expenditure as a percentage of total health expenditure (per person per year)	Percentage	58.5	38
6.	Children receiving full vaccination within 15 months	Percentage	84	95
7.	Individuals with health insurance	Percentage	23	90

**Nutritional Quantitative Targets**

S.N.	Indicators	Unit	Status of Fiscal Year 2080/81 B.S.	Target for Fiscal Year 2085/86 B.S.
1.	Prevalence of stunting (height for age) among U5 children	Percentage	16	4
2.	Prevalence of underweight (weight for age) among U5 children	Percentage	19	10
3.	Prevalence of overweight/obesity among women of reproductive age (15-49 years)	Percentage	28	20
4.	Prevalence of anemia among U5 children	Percentage	49	15
5.	Local levels declared nutrition-friendly	Percentage	5	100

**Quantitative Targets Related to Social Security**

S.N.	Indicators	Unit	Status of Fiscal Year 2080/81 B.S.	Target for Fiscal Year 2085/86 B.S.
1.	Targeted Population Covered by Social Security Systems	Percentage	41.7	80
2.	Social Security Expenditure in the Annual Budget	Percentage	0.9	1.8
3.	Individuals Receiving Assistance through One-Stop Crisis Management Center	Number	3,378	2,900
4.	Senior Citizens Aged 80 and Above Receiving Health Services at Home	Percentage	67	90

**Quantitative Targets Related to Disaster and Crisis Management**

S.N.	Indicators	Unit	Status of Fiscal Year 2080/81 B.S.	Target for Fiscal Year 2085/86 B.S.
1.	Human deaths due to disasters (excluding road accidents) (Annual)	Number	284	200
2.	Economic loss due to disasters (annual)	NPR in crores	30	20
3.	Families affected by disasters (damage to physical structures) (annual)	Number	1290	800
4.	Localities with disaster preparedness and response plans	Number	60	109

### Quantitative Targets Related to Population Management

S.N.	Indicators	Unit	Status of Fiscal Year 2080/81 B.S.	Target for Fiscal Year 2085/86 B.S.
1.	Population growth rate	Percentage	1.24	1.51
2.	Total fertility rate (number of live births per woman)	Percentage	1.91	2.1
3.	Net migration rate	Per hundred thousand	(1131)	(600)
4.	Number of localities with negative population growth	Count	31	20

## 1.3 Overview of Rolpa District

### 1.3.1 Introduction

Rolpa District, one of the 12 districts in the Lumbini Province of western Nepal, is known for its rugged terrain, cultural diversity, and historical significance. The district is characterized by hilly landscapes, traditional settlements, and a unique mix of ethnic communities.

### 1.3.2 Historical Significance

Before the 15th century, the King of Rukumkot ruled over the Rolpa area. Later, King Tuthansen of Salyankot established a separate kingdom called Gajulkot by taking 18 villages from Rukumkot as dowry from King Jayanta Berma. During the Rana regime in 1962, Rolpa was divided between two districts: Pyuthan and Salyan. Rolpa holds a significant place in Nepal's political history, as it was a stronghold of the Maoist insurgency. The district played a crucial role during the Nepalese Civil War (1996-2006), which eventually led to the abolition of the monarchy and the establishment of a federal democratic republic, thus shaping Nepal's political landscape. Many villages in Rolpa, including Thawang, became the base for Maoist operations. The district's history is now a major attraction for researchers and political analysts.

### 1.3.3 Geographical and Political Information

Latitude :83<sup>0</sup>10" to 83<sup>0</sup>90' east latitude  
 Longitude:28<sup>0</sup>38" to 28<sup>0</sup>80" north longitude  
 Total Area: 1879 Sq. Km  
 Length (East-West): 67 Km  
 Breadth (North-South): 28.04 Km

**District Boundaries**

**East:** Baglung and Pyuthan  
**West:** Salyan  
**North:** Rukum East  
**South:** Dang

**Altitude**

Maximum: 3639 meters  
 Minimum: 701 meters  
 Climate: Dry, humid, moist

**Temperature**

Maximum: 32.5<sup>0</sup>C  
 Minimum: 11.8<sup>0</sup>C  
 District Headquarters: Liwang



The district is situated in the Mahabharat and Chure mountain ranges, with elevations ranging from over 800 to 3,600 meters (Jaljala lek) above sea level. There are two popular rivers, named Madi and Lungri, flowing from the west and east of the district, respectively, providing water for irrigation and hydropower potential. The district experiences a temperate climate in the highlands and a subtropical climate in the lower regions.

### 1.3.4 Socio-Demographic Information of Rolpa District

Indicators	Number	Percentage
Total Population	234793	NA
Male	109871	46.8
Female	124922	53.2
Household number	52221	NA
Higher population by ethnic group	100475	42.8
Population Annual Growth Rate	10287	0.43
Average Household Size	4.50	NA
Literacy Rate	Total Literacy Rate	75.6
	Male Literacy Rate	84.0%
	Female Literacy Rate	68.4%
Economically Active Population (> 10 years)	127009	68.1%
Population Density (per Sq. KM)	125	NA
Sex Ratio (males per 100 females)	-	87.95
Human Development Index	-	0.395
Life expectancy rate (Years)	-	66.28
Population with disability	8923	3.8%
Election Constituent (Federal/Province)	½	-
Total number of Municipalities	1	-
Total number of Rural Municipalities	9	-
Total number of Wards	72	-
<b>Source: National Population and Housing Census, 2021</b>		

Rolpa has a population of around 2,34,793 primarily consisting of Magar, Chhetri, Dalit, Brahmin, and Newar ethnic groups. The Magar community is the largest ethnic group, preserving its distinct cultural heritage.

The main languages spoken in the district are Nepali, Magar, and Kham Magar, with indigenous traditions and customs shaping local life. The district has a relatively low population density, and a significant portion of its youth has migrated to India, the Middle East, and Malaysia for employment.

### 1.3.5 Basic Information about Municipalities in Rolpa District

There are a total of 10 local-level units in the Rolpa district. According to the 2014 and 2017 municipal reconstruction processes, this district has been divided into one municipality (Rolpa) and the remaining 9 are rural municipalities (Sunilsmriti, Lungri, Sunchhahari, Thabang, Paribartan, Madi, Sukidaha, Tribeni, and Runtigadhi).

Municipality Name	Total Area (in Square Kilometers)	Total Wards	Households	Population		
				Total	Male	Female
Thawang RM	191	5	2551	10851	5110	5741
Paribartan RM	163	6	4685	21671	9985	11686
Madi RM	130	6	4136	18056	8421	9635
Gangadev RM	124	7	4433	21503	10045	11458
Sunchhahari RM	278	7	3585	17241	8290	8951
Tribeni RM	205	7	5357	23412	11024	12388
Lungri RM	129	7	5489	26825	12585	14240
Sunilsmriti RM	157	8	7015	31117	14504	16613
Runtigadi RM	233	9	6224	28291	13349	14942
Rolpa Municipality	270	10	8746	35826	16558	19268
<b>Total</b>	<b>1880</b>	<b>72</b>	<b>52221</b>	<b>234793</b>	<b>109871</b>	<b>124922</b>

**Source: National Population and Housing Census, 2021**

### 1.3.6 Economic Aspects

Agriculture is the main economic activity in Rolpa, with major crops including maize, millet, wheat, barley, and potatoes. Animal husbandry, particularly goat and cattle farming, plays a crucial role in household incomes. Due to the district's remoteness and lack of industrialization, many residents rely on remittances from foreign employment.

The commercial farming of medicinal herbs and cash crops such as cardamom is growing, but market access remains challenging. The district also holds potential for hydropower development, which could boost its economy. Major market areas of the district are Liwang, Sulichour, Ruinibang, Holieri, Ghartigaun, Khungri, Baghmara, Thabang, Madichour, etc.

### 1.3.7 Cultural Heritage

Rolpa is home to a rich cultural heritage, particularly that of the Magar community. Festivals such as Dashain, Tihar, Maghe Sankranti, Buddha Jayanti, and Lhosar are widely celebrated. Traditional Magar dances and folk music, including Kaura and Maruni, are an essential part of local culture.

The district is also known for its ancient temples, shrines, and Buddhist monasteries. Despite modernization, many indigenous customs, rituals, and beliefs continue to be practiced, reflecting Rolpa's deep-rooted cultural traditions.

### **1.3.8 Infrastructure and Development**

Infrastructure development in Rolpa remains limited, though gradual improvements have been made in recent years. The road network is expanding, but many rural areas still lack proper road connectivity. The Mid-Hill Highway passes through the district, enhancing access to neighboring regions.

Electricity, mobile networks, and banking services are available but not widespread in remote villages. Healthcare facilities remain inadequate, with the district hospital in Liwang being the primary medical center. Access to clean drinking water and sanitation continues to be challenging in some areas.

### **1.3.9 Education System**

Education in Rolpa is improving, but challenges remain due to geographical difficulties and limited resources. The district has several public and private schools, with institutions such as Rolpa Multiple Campus serving as a higher education center.

However, most students move to Dang, Kathmandu, or Butwal for advanced education. Government efforts and NGO initiatives are working towards improving literacy rates and promoting technical and vocational training. The literacy rate of the Rolpa district is 75.6% as of the 2021 census.

### **1.3.10 Tourist Attractions**

Despite its rugged terrain, Rolpa has several **natural and historical sites** that hold great tourism potential. Famous tourism places within the district, which also have historical importance, are Jaljala, Shivalaya temple, Gurung tole, Shiva Gufa, Gadhi lekh, Sakhi lekh (Runti), Tripureswori Bhagwati, Rock Garden, Sunchhahari waterfalls, View tower, ChunaareBhir, etc. The details of the major tourist places of the Rolpa district.

- 1. Thawang Village:** Known as the birthplace of the Maoist movement, it has historical significance and stunning landscapes.

2. **Jaljala Hill:** A scenic hilltop offering panoramic views of the **Dhaulagiri and Annapurna ranges**.
3. **Liwang:** The district headquarters, known for its traditional Magar settlements.
4. **Buddhist Monasteries:** Important religious sites reflecting the influence of Buddhism in the region.
5. **Hiking and Trekking Routes:** Offering adventure tourism opportunities in the hills and forests of Rolpa.
6. **Rock Garden:** A garden built as a tourist spot on Sat Dobato Hill by the Rolpa Municipality.

## **1.4 Health Office Structure and Systems**

### **1.4.1 Introduction**

The district health system has been globally recognized as the core mechanism for the delivery of Primary Health Care Services. Since the Harare Conference 1987, the World Health Organization (WHO) has also given priority to strengthening the District Health System (DHS) to improve Primary Health Care Service Delivery. These Essential Health Care Services are administratively and institutionally organized at the district level, offering the best possibility for optimization of critical factors, viz, access, quality, planning, supervision, monitoring, evaluation, and the management of the personnel and other resources, as well as inter and intra sectoral coordination.

Previously district health system was run and functional through the network of the Ministry of Health and Population (MoHP) and its constituent organizations. Under the federal government, now the pattern is shifted, and its functions are implemented through the provincial government of Lumbini province under the MoHP. Health facilities under the local government run in coordination with the provincial and federal governments.

The Terms of Reference (TOR) of the Health Office (HO), Rolpa are:

1. Coordination, facilitation, liaison to the province and local level government under the health directorate, and implementation of the program as per the guidance and direction of the province.
2. Prepare the storage and distribution plan of vaccines, essential and urgent medicines, and equipment at the quality control and monitoring under the district through the eLMIS system.
3. Facilitate and coordinate with the concerned district stakeholders for the management of the public health disaster/epidemic and vector surveillance.
4. Facilitate and coordinate with the concerned district stakeholders to conduct different public health campaigns.

5. Coordinate with local government and service outlets, and concerned stakeholders.
6. Study and analysis of the integrated health management information system, prepare a plan, and facilitate and share the feedback at the local level.
7. Prepare the plan, coordinate, and facilitate to improve access and utilization of quality health services.
8. Regulate, supervise, monitor, and quality improvement of government, non-government, and private program activities and cooperative health institutions.
9. Technical capacity building of the human resources and organization
10. Coordinate, facilitate, and implement the province's special health program and other regular public health programs (like tuberculosis, leprosy, family planning, lymphatic filariasis, nutrition, measles/rubella vaccine/vaccination, and other special programs)
11. Promotion and management of environmental health, safe drinking water, sanitation, and occupational health
12. Population management-related tasks
13. Implementation of activities provided by the provincial government
14. Multisectoral coordination and facilitation
15. Internal administration (Financial, Administration, and Management) related works.

This chapter presents the findings related to the HO structure and systems to cover the TOR of HO, Rolpa. The areas covered by this chapter are: service delivery points, management system, health service workforce, monitoring and evaluation system, Integrated Health Management Information System (IHMIS), and disaster management system.

#### **1.4.2 Service Delivery Points in Rolpa District**

As a whole, there are 126 peripheral health facilities (private and government) representing all wards of the district. One 50-bed provincial hospital having CEONC services, 1 basic hospital, 2 PHCCs having BEONC services, 48 HPs, 22 Basic Health Service Centers (BHSC), 5 Urban Health Clinic (UHC), 41 Community Health Units (CHUs) governed by the local level, 63 Birthing Centers, 182 PHC/ORCs, 219 Immunization Clinics, and 224 Immunization Sessions. The total number of Female Community Health Volunteers (FCHVs) is 459. There are 29 IUCD and 59 Implant service sites, and we have planned to be listed and declared as having availability of at least six FP methods in all health facilities, including Sayana Press. Altogether 46 Medical Abortion (MA) sites are listed in the district. In total, there are 73 SBA nurses in the district, serving in 13 RUSG sites. In addition, with this other, a few registered health clinics, pharmacies, and national and international non-governmental organizations are working in the health sector in the district with the close coordination of the Health Office, Rolpa.

<b>Service Delivery Points in Rolpa District</b>	
<b>Type of service delivery points</b>	<b>Number</b>
Provincial Government Hospital	1
Local Level Basic Hospital	1
Primary Health Care Center (PHCC)	2
Private Health Facility (Hospital and NGO)	3
Health Posts	48
Basic Health Service Center	22
Community Health Unit	41
Urban Health Center	5
Comprehensive Emergency Obstetric and Neonatal Care (CEONC) Site	1
Basic Emergency Obstetric and Neonatal Care (BEONC) Sites	2
Birthing Centers	63
Primary Health Care Out-Reach Clinic (PHC/ORC)	182
Immunization Clinic	219
Immunization Session	224
Vaccination Distribution Center	10
OTC Sites	10
Directly Observed Treatment Short-course (DOTS) Center	75
Anti-Retroviral Therapy (ART) Service Site	1
Prevention of Mother-To-Child Transmission (PMTCT) Site for HIV	75
Community-Based (CB)-PMTCT Sites for HIV	0
HIV Testing and Counseling (HTC) Site	1
Female Community Health Volunteers (FCHVs)	459
Intra-Uterine Contraceptive Device (IUCD) Service Sites	29
Implant Service Sites	59
Six FP methods, Sites with Sayana press	29
Medical Abortion Site	46
Routine Ultrasound Sonography (RUSG) Service site	13

**1.4.3 Management system**

Under the management system, HO Rolpa held different meetings every month, which include the monthly HO staff meeting and monthly review meetings of the program of the health facility in-charges at 10 municipal level reporting centers. HO Rolpa also holds quarterly meetings of the Reproductive Health Coordination Committee (RHCC), District Immunization Coordination Committee (DICC), etc. In addition, the Health Office, Rolpa, organized the different sorts of coordination meetings with relevant line agencies and stakeholders to build a common consensus to promote and strengthen the quality health system throughout the district.

The monthly review meeting of the HF in charge at each municipality is organized on the 8<sup>th</sup> day of every month. A monthly review meeting is regularly organized at the district level on the 15<sup>th</sup> day of every month, which is a major innovation of the HO, Rolpa.

All HFs have their own Health Facility Operational and Management Committee (HFOMC) led by the ward chairperson, and their meeting used to be conducted routinely and as needed for the community levels' quality health services. FCHVs and Health Mother Group (HMG) meetings have been organized each month in respective wards.

**1.4.4 Health Service workforce**

<b>Current Staff Sanctioned Post of Health Office, Rolpa (FY 2081/82)</b>		
<b>HO Staffs</b>	<b>Numbers</b>	<b>Status</b>
<b>a.</b> Sr/Public Health Officer	0	Vacant
<b>b.</b> Public Health Officer	1	<b>Bonding</b>
<b>c.</b> HA/Public Health Supervisors	2	Filled
<b>d.</b> Public Health Nurse	1	Filled
<b>e.</b> Statistics Assistant/Officer	1	Filled
<b>f.</b> Cold Chain Assistant	1+1	<b>Filled+Contract</b>
<b>g.</b> Laboratory Technician	1	Filled
<b>h.</b> Administration Assistant/Officer	1	Filled
<b>i.</b> Accountant/Officer	0	Vacant
<b>j.</b> Office Assistants	3	Filled
<b>k.</b> Driver	1	Filled
<b>Total</b>	<b>13</b>	

#### **1.4.5 Monitoring and Evaluation System**

The Rolpa Health Office conducts regular monitoring and evaluation through field visits, onsite coaching for health workers, and supportive supervision to ensure quality services in public health facilities, to track service readiness, staff capacity, and health service indicators. Data quality assessments and regular review meetings were also conducted to provide feedback for strengthening health programs.

#### **1.4.6 Integrated Health Management Information System**

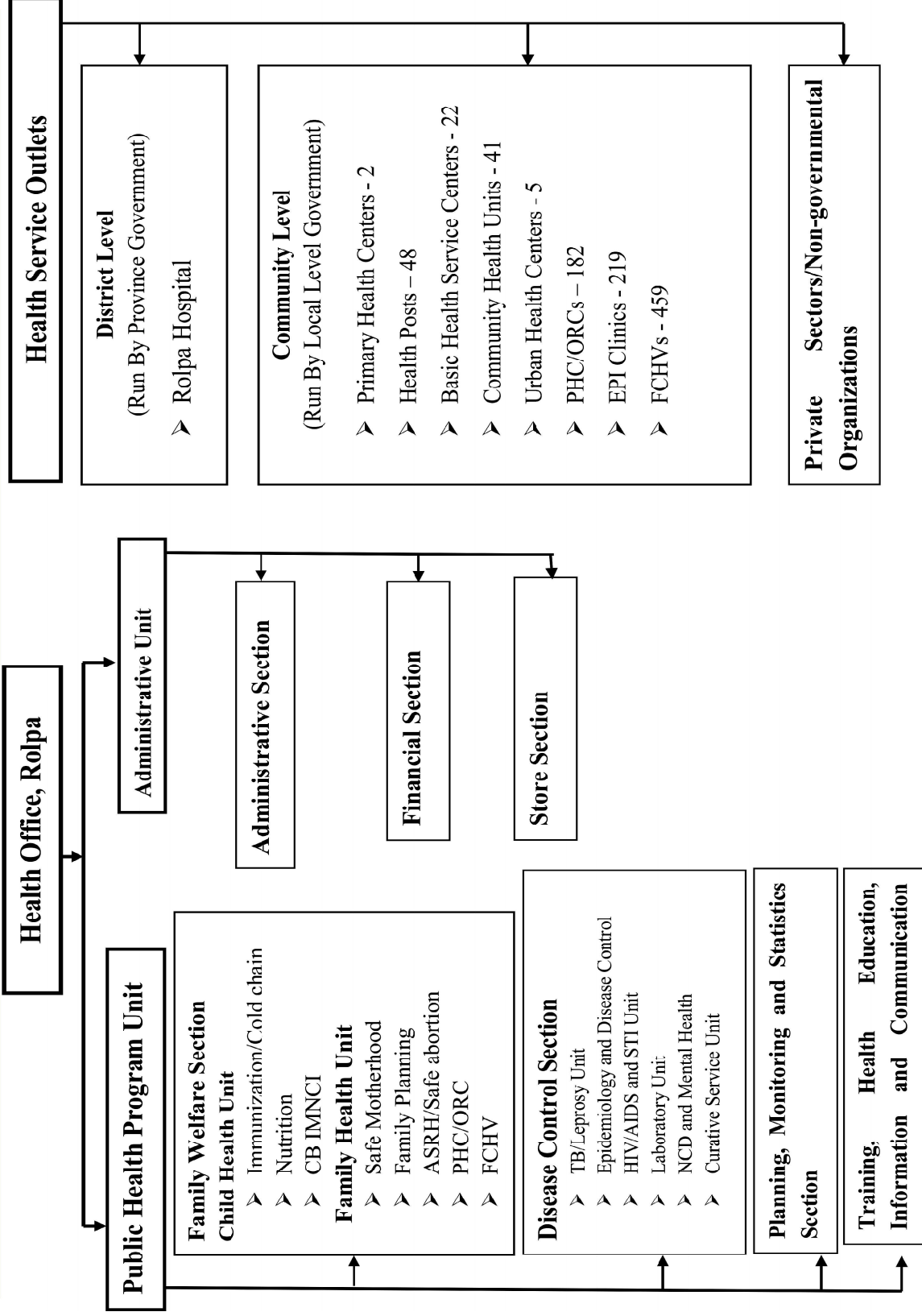
Rolpa District utilizes DHIS-2 to collect, manage, and analyze health data from health facilities to track progress towards health targets and identify areas for improvement, and evidence-based decision-making for resource allocation, policy formulation, and program planning.

#### **1.4.7 Disaster Management System**

Being a member of the District Disaster Management Committee (DDMC) as per the Disaster Risk Reduction and Management Act 2017, chaired by the Chief District Officer (CDO), HO Rolpa is playing a vital role as assigned in the area of disaster management, which focuses on Health and Nutrition. Furthermore, HO has its own Rapid Response Team (RRT) at the district level, having 11 members, which is actively mobilized if there is any outbreak or epidemic.

In addition, there is a local level Rapid Response Committee and RRT at all local levels, which has members' representation from Municipal level elected officials, health, agriculture, veterinary, forestry, school, post office, and so on. If there is any outbreak or epidemic, at first, the local level RRT will be mobilized, and if the condition is out of their control RRT at the district level will add support and mobilize as needed. Likewise, if the district level RRT is also unable to control the situation, then the province health emergency operation center, the national health emergency operation center, and EDCCD are summoned for further action.

# Institutional Framework of Health Office, Rolpa



**Details Information Regarding Health Facilities and Community-Level Institutions**

S.N.	Name of LLG	Total wards	Total HFs (Govt, Pvt, NGO)	Total no. of Health Workers	Total FCHVs	Immunization Clinics (Monthly)		PHC/ORC	Vaccine Distribution Centers
						Immunization clinics	Immunization Sessions		
1	Rolpa Mun	10	24	63	63	28	33	23	1
2	Sunchahari RM	7	14	26	53	22	22	19	1
3	Thawang RM	5	9	17	27	12	12	11	1
4	Paribartan RM	6	10	37	45	21	21	19	1
5	Gangadev RM	7	9	40	33	15	15	13	1
6	Madi RM	6	10	35	36	14	14	17	1
7	Tribeni RM	7	7	45	45	23	23	17	1
8	Runtigadhi RM	9	12	47	57	32	32	29	1
9	Sunilsmruti RM	8	11	50	55	28	28	24	1
10	Lungri RM	7	20	50	45	24	24	10	1
<b>Total</b>		<b>72</b>	<b>126</b>	<b>410</b>	<b>459</b>	<b>219</b>	<b>224</b>	<b>182</b>	<b>10</b>

## FAMILY WELFARE PROGRAM

### 2.1 Maternal and Newborn Health

#### 2.1.1 Introduction

Maternal and neonatal health (MNH) is a priority program for the Government of Nepal, and has made it a part of the Basic Health Services (BHS) package based on the Public Health Service Act 2015.

When the Safe Motherhood Policy was adopted in 1998 (2054/55), the investment journey in MNH was underway. This was later strengthened in 2006 (2062/63) by the National Policy on Skilled Birth Attendants (SBAs). Policy supplemented by National Policy on Skilled Birth Attendants (SBAs) 2062/63(2006) adopted two key strategies to improve maternal health: ensuring that selected health facilities have emergency obstetric care services that are available 24 hours a day, and the presence of health personnel with midwifery skills who can competently provide safe and effective delivery care.

In 2001, only 9% of Nepali women gave birth in a health institution, and two in three women reported that inadequate money for treatment was a barrier to accessing health care. Nepal showed notable socioeconomic and geographic differences, with 89% of urban households and only 41% of rural households living within 30 minutes of a medical facility. Similarly, 57% of households in the wealthiest quintile had access to a health facility within 30 minutes, compared to only 29% of households in the poorest quintile. In response to these difficulties, the Government of Nepal has highlighted institutional births as a fundamental strategy to enhance maternal health. As an effort to remove financial obstacles that deterred women from seeking deliveries in facilities and promote institutional deliveries, the Maternity Incentive Scheme (MIS) was launched in Nepal in July 2005. The initiative initially offered financial incentives of NPR 1,500 in the Himalayan regions, NPR 1,000 in the hilly regions, and NPR 500 in the Terai to women giving birth at public health facilities. The percentage of institutional deliveries in Nepal has significantly increased over the years, with the proportion of live births assisted by a skilled provider rising from 10% in 1996 to 80% in 2022, as per the Nepal Demographic and Health Survey (NDHS) 2022. Similarly, the maternal mortality ratio (MMR), which was 539 per 100,000 live births in 1996 as per the Nepal Family Health Survey (NFHS), has significantly decreased as a result of these initiatives, falling to 151 in 2021 as per the National Population and Housing Census 2021: A maternal mortality report. Similarly, the Neonatal Mortality Rate (NMR) decreased from 50 per 1,000 live births in 1996 to 21 per 1,000 live births in 2022, and the Under-five mortality rate decreased from 118 per 1,000 live births in 1996 to 33 per 1,000 live births in 2022, as per NDHS 2022.

The achievement is attributed to the implementation of progressive policies, strategies, and guidelines to ensure accessible, affordable, and quality maternal health services, particularly for the unreached population. Despite this progress, accelerated efforts are needed to meet the SDG targets by 2030—aiming for an MMR below 70 per 100,000 live births, an NMR below 12 per 1,000 live births, and a U5 mortality rate below 25 per 1000 live births.

This achievement is credited to the adoption of progressive policies, strategies, and standards that guarantee maternal health care that is high-quality, affordable, and accessible, especially for marginalized and underserved populations. Nepal is committed to achieving the Sustainable Development Goals (SDGs) and the goals outlined in the Global Strategy for Women’s, Children’s, and Adolescents’ Health (2016–2030). However, to achieve the SDGs targets by 2030, which include bringing the MMR down to less than 70 per 100,000 live births, the NMR to less than 12 per 1,000 live births, and the U5 mortality rate to less than 25 per 1,000 live births, greater efforts are required. The 2018 Global Strategy Monitoring Report emphasizes that, both internationally and regionally, progress toward accomplishing the SDGs has been slowed in several crucial action areas. It highlights the necessity of bolstering multi-sectoral and multi-stakeholder initiatives throughout the lives of women and children.

Global evidence shows that all pregnancies are at risk, and complications during pregnancy, delivery, and the postpartum period are difficult to predict. Evidence suggests that three key delays are of critical importance to the outcomes of an obstetric emergency in Nepal:

(i) delay in seeking care, (ii) delay in reaching care, and (iii) delay in receiving care.

To reduce the risks associated with pregnancy and childbirth and address these delays, three major strategies have been adopted in Nepal:

1. Promoting birth preparedness and complication readiness, including awareness raising and improving the availability of funds, transport, and blood supplies.
2. Expansion of 24-hour birthing facilities alongside the AamaSurakshya Program promotes a continuum of care from antenatal care (ANC) to post-natal care (PNC).
3. Expansion of 24 hour emergency obstetric care services (basic and comprehensive) at selected health facilities in every district.

## 2.2.2 Goal and Outcomes of Nepal Safe Motherhood and Newborn Health Roadmap 2030

**Goal:** Ensuring healthy lives and promoting well-being for all mothers and newborns.

**Outcomes:**

1. Increased availability of high-quality maternal and newborn health services, leaving no one behind
2. Increased demand for and utilization of equitable maternal and newborn health services
3. Improved governance and ensured accountability of maternal and newborn health services.
4. Improved monitoring and evaluation of maternal and newborn health services.
5. Strengthened the emergency preparedness of maternal and newborn health services.

Quality is a central principle of the Road Map and has been integrated across these five outcomes.

### 2.1.3 Major interventions of the MNH Program at the national level

**a. Community-level maternal and newborn health interventions**

**i. Matri Suraksha Chakki (MSC):** The distribution of Matri Suraksha Chakki (MSC), which contains misoprostol to prevent postpartum hemorrhage (PPH), was initiated by the Government of Nepal (GoN) during the fiscal year 2066/67. Female Community Health Volunteers (FCHVs) were trained to give 600 mcg of MSC Chakki to pregnant women in their eighth month of pregnancy (three 200 mcg tablets). Especially during home deliveries, these women are advised to take the tablets orally as soon as possible after giving birth and before the placental removal to prevent PPH.

**ii. Rural Obstetrics Ultrasound Program:** The Rural Obstetrics Ultrasound Program aims for the timely identification of pregnant women with risks of obstetric complications in remote districts and timely referral to Comprehensive Emergency Obstetric and Newborn Care (CEmONC) sites. Obstetric ultrasound-trained SBA nurses are mobilized to scan pregnant women at rural Primary Health Care Centers (PHCCs) and health posts using a portable ultrasound machine. Women with detected abnormalities such as abnormal fetal lie, presentation of the fetus, congenital anomaly, and placenta praevia are referred to a CEmONC site.

**b. Emergency Obstetric Care:** Basic emergency obstetric care (BEOC) covers management of pregnancy complications by assisted vaginal delivery (vacuum or forceps), manual removal of placenta, removal of retained products of abortion (manual vacuum aspiration), and administration of parental drugs (for post-partum hemorrhage, infection, and pre eclampsia/eclampsia), resuscitation of newborn,

and referral. Comprehensive emergency obstetric care (CEOC) includes surgery (cesarean section), anesthesia, and blood transfusion, along with BEOC functions. Safe blood transfusion is an essential part of the CEOC, and to support this, the national blood transfusion policy was revised in 2006, and a blood transfusion guideline was developed.

**c. Expansion and quality improvement of service delivery sites:** FWD continued to expand 24/7 service delivery sites like birthing centers, Basic Emergency Obstetric and Newborn Care (BEmONC), and CEmONC sites at health facilities. The expansion of service sites is possible mostly due to the provision of funds for hiring staff locally on a contract basis. Expansion of the CEmONC sites has also met with the challenge of maintaining the functionality and quality of CEmONC services at the service delivery sites, especially in the remote areas, with human resource constraints being the most common reason for non-functionality. A study by FWD showed that the establishment of CEmONC sites in 15-bedded hospitals in accessible areas of the terai and the hills can potentially drive human resource shortages in the remote areas in the absence of appropriate incentive mechanisms for remote areas. It is prudent to conduct a mapping exercise for EmONC. Furthermore, with 57% of the maternal deaths happening at the health facilities as per NPHC 2021, it's necessary to have multispecialty teams at the referral sites to manage maternal complications.

**d. On-site clinical coaching and mentoring:** Good coaching and mentoring are essential for improving mentees' abilities, competence, self-assurance, and drive while building professional networks for their growth and future leadership. To improve the standard of care at birthing centers, BEmONC, and CEmONC facilities, the FWD has implemented a coaching and mentoring approach. Evidence suggests that training alone is not enough to guarantee high-quality healthcare, even if the NHTC offers ASBA and SBA training. An enabling climate, ongoing capacity building, and follow-up assistance are crucial.

**e. MNH readiness of hospital and BC/ BEmONC for quality improvement:**

The process of raising the quality of care (QoC) in medical facilities is a two-step process. The first stage is to make sure the facility has the infrastructure, tools, drugs, and personnel it needs. Implementing focused quality improvement initiatives is the second step in providing high-quality care. To minimize avoidable maternal and newborn deaths and stillbirths by 2030, global initiatives such as Every Newborn Action Plan (ENAP) and the Strategies for Ending Preventable Maternal Mortality (EPMM) are in line with the SDGs. It will take targeted improvements in QoC during pregnancy, labor, and the postpartum phase to meet these goals.

**f. Emergency referral funds:** It is estimated that around 15% of pregnant women will develop potentially life-threatening complications that need skilled health care. Women may need immediate referral from BC/BEmONC to nearby hospitals where CEmONC services are available. An effective referral system

is important for ensuring the timely and efficient transfer of patients to higher levels of care, especially during obstetric emergencies. So, the main objective of this program is to support emergency transport during referral of women and newborns from the disadvantaged population (poor, Dalit, janajati, and socially marginalized groups).

**g. Aamasurakshya program and free newborn program:** Initiated as Maternity Incentive Scheme in 2061 B.S. (2005) by providing transport incentives to women to deliver in health facilities, the program gradually covered user fees for all types of delivery care in 25 low human development index (HDI) districts in 2006 AD and was expanded nationwide as the AamaProgramme in 2065 (2009). In 2068 (2012), the separate 4 ANC incentives program was merged into it, and in 2074 (2017) free newborn program was also merged with the Aama Program. The program incentivizes the women and the health facilities for health service utilization covered by the program.

Pregnant women receive a **total of NPR 800** if they complete the recommended four ANC visits at a government-approved health facility. The program provides cash incentives to pregnant women to cover transportation costs based on geographical regions, i.e., Rs. 3,000 in the mountain region, Rs. 2,000 for the Hill region, and Rs. 1,000 for the Terai region.

Health facilities get reimbursement by unit cost: NPR 2,500 for normal delivery, NPR 4,000 for complicated delivery, NPR 10,000 for cesarean section, NPR 5,000 for Anti-D, and NPR 7,000 for Molar pregnancy. And for newborn care, the health facility gets additional reimbursement based on unit cost for providing free newborn services based on the level of care. As per Free Newborn Care Package Adopted from “NisulkaNawajaatShishuUpacharkaryakramKaryabidhi Nirdeshika 2074”, the health facility will be reimbursed Rs. 0 for providing Package “0”; Rs. 1000 for Package “A”; Rs. 2000 for Package “B”; & Rs. 5000 for Package “C”.

**h. Newborn Care:** Newborn care includes health education and behavior change communication on essential newborn care practices, Identification of neonatal danger signs, and timely referral to the appropriate health facility. Delivery by skilled birth attendants both at home and health facility, immediate newborn care (warmth, cleanliness, immediate breastfeeding, cord care, eye care, and immunization), and newborn resuscitation.

**i. Special newborn care unit:** A Special Newborn Treatment Unit (SNCU) is a specialized hospital unit that offers specialized treatment for ill and small babies and is manned by a medical officer, nurses, and paramedics. Premature birth, low birth weight, or medical conditions, including jaundice, low blood sugar, or respiratory problems, can all cause babies to need SNCU care. At least 12 beds should be available

in a district hospital SNCU, with an extra 4 beds added for every 1,000 deliveries over 3,000 per year. Despite continuous efforts of the GoN, the NMR (Neonatal mortality Rate) in the country has been stagnant over the last six years (i.e., 21 per 1000 live births in both NDHS 2016 and NDHS 2022). Acknowledging the heightened vulnerability of small newborns to mortality and morbidity, and to meet the goal of bringing newborn mortality down to 12 per 1,000 live births by 2030, Nepal's Ministry of Health and has launched targeted programme to offer specialized care through three levels - newborn corners at the delivery rooms/ operation theatres, special newborn care units (SNCUs) and neonatal intensive care units (NICUs).

A customized mentoring program that focuses on critical clinical skills for managing SSNBs at every point of contact has been piloted by FWD for all healthcare professionals working in SNCU Level-II facilities. The introduction of an orientation package and the development of a Nepal-specific model of care for small and sick newborns (SSNBs) at Level-II health facilities are other initiatives. This orientation package functions as a supplemental, condensed tool to offer crucial information and mentor-decision-making while the nationwide comprehensive newborn care training is still in progress. It will be crucial in preparing medical staff at Level II hospitals to handle typical SSNB problems and consequences. The WHO-UNICEF ten-component framework, which covers topics like vision, political commitment, financing, human resources, infrastructure, equipment, data systems, referral networks, maternal-newborn care linkage, community support, and post-discharge follow-up, serves as the foundation for Nepal's care for the SSNB model. Following workshops and consultations, the model was modified to fit the Nepali environment, resolving any shortcomings and difficulties in scaling up each element. At the moment, Level-II medical institutions in the Bagmati Province's Dhading, Trishuli, Sindhuli, and Hetauda hospitals are piloting the Nepal-specific concept.

**j. Nyano Jhola Program:** The Nyano Jhola Program was launched in 2070/71 to protect newborns from hypothermia and infections and to increase the use of peripheral health facilities (birthing centers). Two sets of clothes (bhoto, daura, napkin, and cap) for newborns and mothers, and one set of wrapper, mat for baby, and gown for mother are provided for women who give birth at birthing centers and district hospitals. The program was interrupted due to financial constraints; however, MOH allocated extra budget due to popular demand.

**k. Maternal and perinatal death surveillance and response (MPDSR):** The Maternal and Perinatal Death Surveillance and Response (MPDSR) is a systematic process of identifying, reporting, analyzing, and determination of the causes of maternal and perinatal deaths and their prevention method. The primary goal is to use this information to guide public health actions, monitor their effectiveness, and ultimately eliminate preventable maternal and perinatal mortality. The National MPDSR Committee,

which is chaired by the Director General of the DoHS, and the MPDSR Technical Working Group (TWG), which is headed by the Director of the FWD, are operating following the MPDSR guidelines. The provincial health directorate, health office, health facility, and local level governments have also established the MPDSR committees. Following a maternal death, the MPDSR committees at respective hospitals and local levels must meet within 72 hours of maternal death, and hospital committees meet once a month for perinatal deaths. The TWG and the national committee are required to meet quarterly or more frequently as needed.

**l. Newborn birth defect surveillance:** One of the main causes of child mortality, birth defects, also known as congenital anomalies, are structural or functional abnormalities that arise during pregnancy and can be identified either before or after birth. Prompt care and treatment can prevent disability, improve outcomes, and save lives. In such events, birth defect surveillance helps in timely tracking the trends in the occurrence of birth defects, providing quantitative estimates of their prevalence so that we can make timely interventions. The surveillance for newborn birth defect (NBBDD) was initiated in 2071/72 in 10 hospitals and has now been implemented in 27 hospitals in FY 2080/81.

**Criteria for Birth Defects Surveillance**

1. Online Hospital-based at birth surveillance
2. Passive reporting system: passive reporting of cases from hospitals
3. Gestational age: All births from e" 28 weeks of gestation (if gestational age not known: birth weight e"1000 gms)
4. Pregnancy outcome: Live births and stillbirths
5. Age at Diagnosis: At birth and until 7 days of age
6. Inborn cases: only babies born in the BD Surveillance implementing hospital
7. Mandatory to report: eight major externally visible birth defects (Neural tube defects, Oro-facial clefts, Talipes equinovarus, Limb reduction defects, Hypospadias, Gastroschisis, Exomphalos/Omphalocele, and Imperforate anus)
8. All external/internal birth defects are based on the ability to detect

**m. Safe Abortion Services:** Preventing unwanted pregnancies through quality family planning services is a first step towards addressing women's reproductive health needs, and increasing access to safe abortion services has been considered as a missed opportunity to prevent unwanted pregnancy; however, there is a global need to make this service available to prevent mortality and morbidity from unsafe abortion. A comprehensive approach needs to be integrated between three services: family planning, safe abortion, and post abortion care. This means ensuring the availability of comprehensive abortion care (CAC) that refers termination of unwanted pregnancies through safe techniques with effective pain management, post-procedure family planning information, and services to ensure women can plan

when to have children and avoid further unwanted pregnancies. Only trained and registered doctors, as well as health workers, especially nursing staff, can provide safe abortion services at the HFs approved by the government, with the consent of women, by following the protocol.

### 2.1.4 Service delivery sites of the MNH program in the Rolpa district

HO, Rolpa has been providing Safe Motherhood Program support through all Health Facilities and PHC ORCs. CEONC and BEONC services are provided through Rolpa Hospital and two PHCCs (Sulichaur and Holeri), respectively. Sixty-one HFs are performing as Birthing Centers. Nepal Red Cross Society, Rolpa district chapter, is providing the blood transfusion services with close coordination with concerned stakeholders throughout the district.

Service delivery sites	Fiscal Year		
	2079/80	2080/81	2081/82
Number of CEONC Sites	1	1	1
Number of Functional BEONC Sites	2	2	3
Number of Birthing Centers	53	58	63

#### Total RUSG Sites and Service Providers in the Rolpa district in FY 2081/82

S.N.	Organization	Name of RUSG Sites	Name of Service Provider	No of Sites
1	Sunchhahari RM	Jailwang HP	Lila K.C.	1
2	Thabang RM	Thabang Basic Hospital	Tripura Pun Magar	1
		BHSC Ghorabang	Dipa Buddha	1
3	Paribartan RM	Paribartan RM	Nanda Buddha	1
4	Gangadev RM	Rank HP	Santa Buddha Magar	1
		BHSC Kukurgare	Mangala Dangi	1
5	Madi RM	Ghartigaun HP	Bipana Buddha	1
6	Tribeni RM	Tribeni RM	Krishna B.C.	1
		Nerpa HP	Motikala K.C.	1
7	Rolpa Mun	Liwang HP	Kamala Gurung	1
8	Runtigadhi RM	Holeri PHC	Bimala Gharti	1
9	Sunil Smriti RM	Sulichour PHC	Nisha Giri	1
10	Lungri RM	Wadachour HP	Sunita Roka Chhetri	1
<b>Total RUSG Sites</b>				<b>13</b>

## 2.1.5 Key Indicators of the MNH Program in Rolpa

### 2.1.5.1 Major Indicators of the MNH Program in Rolpa District

Indicators	Fiscal Year		
	2079/80	2080/81	2081/82
% of pregnant women who had at least one ANC checkup	91.3	92.3	101.2
% of pregnant women who had their first ANC checkup as protocol	67.1	76.3	85.3
% of pregnant women who had four ANC checkups as per protocol	64.1	69.4	76.4
% of pregnant women who had eight ANC checkups as per protocol	23.9	53.9	60.9
% of pregnant women tested for HIV	63.5	85.3	90.5
% of pregnancies terminated by induced procedure at health facility-medical	0	0	0
% of pregnancies terminated by induced procedure at health facility-surgical	0	0	0
% of Institutional deliveries	66.7	65.5	68.2
% of Institutional Deliveries by SBA-trained ANM	41.9	46.2	48.9
% of Institutional Deliveries by Skilled Health Personnel (SHP)	4.61	3.17	3.46
% of Institutional deliveries under 20 years	18.3	19.4	15.8
% of deliveries by Cesarean Section	3.2	2.38	2.07
% of women who received PNC within 24 hours of delivery	66.3	66.3	68.4
% of women who had 3 PNC checkups as per protocol	67.4	71.3	77.7
% of neonates who received 4 PNC checkups as per protocol (PNC visits 4 times as per protocol)	48.5	62	73.1
No. of home deliveries	71	95	35
Total number of women who received PAC services	113	86	112
Number of women screened for cervical cancer	1308	1172	1852
Number of women screened for breast cancer	306	1163	1165
Number of women screened for pelvic organ prolapse	1036	1781	1750
Number of women screened for obstetric fistula	86	668	411
% of women managed with a ring pessary (Only for Pelvic Organ Prolapse)	215	264	208
No. of Maternal Deaths	4	0	7
No. of Neonatal Deaths	20	4	5
No. of Still Births	45	40	31
Number of women (<20 years) having a medical abortion	69	49	52
Number of women (<20 years) having a surgical abortion	11	3	1
Number of women (≥20 years) having a medical abortion	805	848	832

The percentage of pregnant women who had at least one ANC check-up at any time, first ANC check-up as per protocol, four ANC checkups, and eight ANC checkups were in increasing trend and were 101.2%, 85.3%, 76.4% and 60.9% respectively in fiscal year 2081/82 in Rolpa district. Similarly, the percentage of institutional delivery was 68.2% in fiscal year 2081/82 and has increased since the last fiscal year. The percentage of institutional deliveries by SBA-trained ANM was in an increasing trend and was 48.9% in fiscal year 2081/82. There were still 34 home deliveries in fiscal year 2081/82 B.S. Likewise, the percentage of women who received PNC visits in 24 hours of delivery, three and four PNC check-ups as per protocol, were in increasing trend since the last three fiscal years and were 68.4%, 77.7% and 73.1% respectively, in fiscal year 2081/82 B.S.

Also, the number of women screened for cervical cancer was 1852 in fiscal year 2081/82. The number of maternal and neonatal deaths was seven and five in fiscal year 2081/82, and has increased since the last fiscal year, which is of great concern.

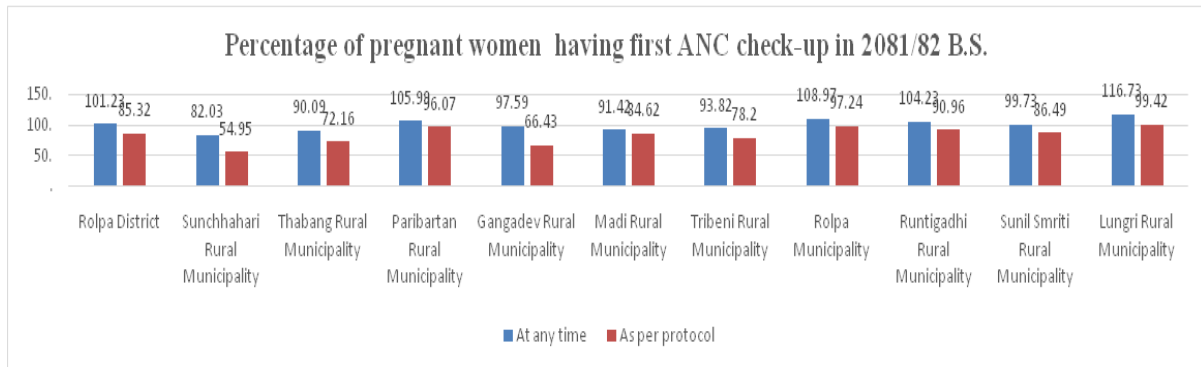
#### **2.1.5.2 Palika-wise distribution of ANC visits**

Till FY 2078/79, a minimum of four ANC visits was measured as complete ANC visits. However, in FY 2079/80, the ANC protocol was revised and a pregnant woman with eight ANC visit was considered to have complete ANC visit (1<sup>st</sup> up to 12 weeks, 2<sup>nd</sup> at 20 weeks, 3<sup>rd</sup> at 26 weeks, 4<sup>th</sup> at 30 weeks, 5<sup>th</sup> at 34<sup>th</sup> weeks, 6<sup>th</sup> at 36 weeks, 7<sup>th</sup> at 38 weeks and 8<sup>th</sup> at 40 weeks, and return to home at 41 weeks if not given birth).

#### **During ANC check-up following services are provided;**

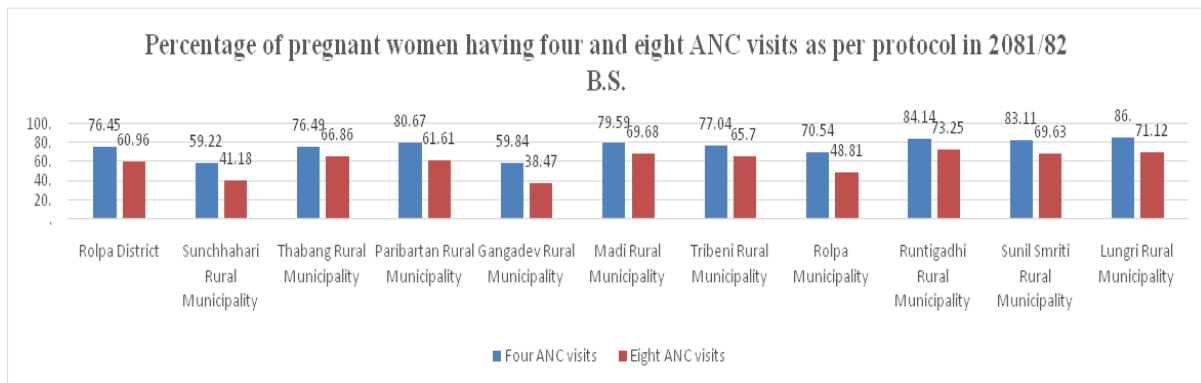
- Monitor blood pressure, weight, and fetal heart rate;
- Provide information, education, and communication (IEC) and behavior change communication (BCC) for danger signs and symptoms, and about the delivery care during pregnancy and timely referral to the appropriate health facilities;
- Birth preparedness and complication readiness (BPCR) for both normal and obstetric emergencies (delivery by skilled birth attendants, money, transportation, and blood); Early detection and management of complications;
- Provision of tetanus diphtheria (TD) immunization, iron tablets, deworming tablets to all pregnant women, and malaria prophylaxis where necessary

**a. Percentage of First ANC visit (at any time) and as per protocol (Palikawise)**



The percentage of pregnant women having their first ANC check-up as per protocol was less than the percentage of pregnant women having their first ANC check-up at any time in Rolpa district. The percentage of pregnant women who had their first ANC visit as per protocol was 85.32% in fiscal year 2081/82 in Rolpa district, with the highest in Lungri Rural Municipality (99.42%) and lowest in Sunchhahari Rural Municipality (54.95%).

**b. Percentage of Four and Eight ANC visits as per protocol (Palikawise)**



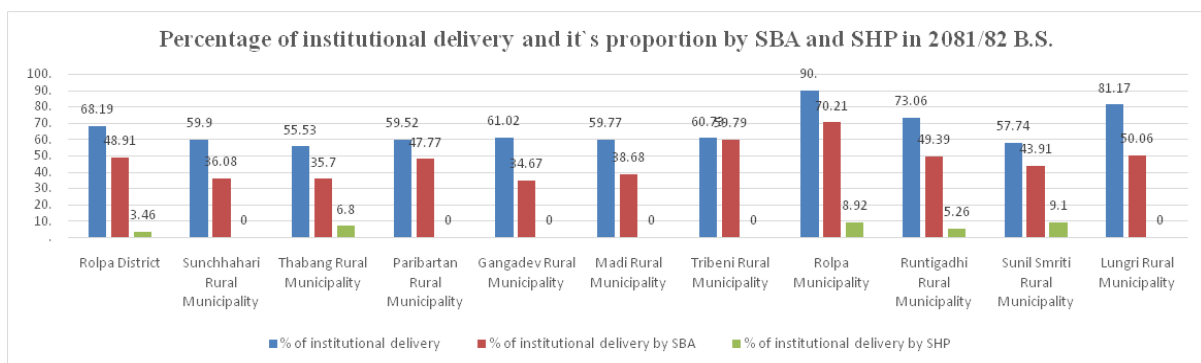
The percentage of pregnant women having eight ANC check-ups as per protocol was less than the percentage of pregnant women having four ANC check-ups as per protocol in Rolpa district. The percentage of pregnant women who had four ANC visits as per protocol was 76.45% in fiscal year 2081/82 in Rolpa district, with the highest in Lungri Rural Municipality (86%) and lowest in Sunchhahari Rural Municipality (41.18%). Similarly, the percentage of pregnant women who had eight ANC visits as per protocol was 60.96% in fiscal year 2081/82 in Rolpa district, with the highest in Runtigadhi Rural Municipality (73.25%) and the lowest in Gangadev Rural Municipality (38.47%).

### 2.1.5.3 Palika-wise distribution of delivery care services

Delivery care services include:

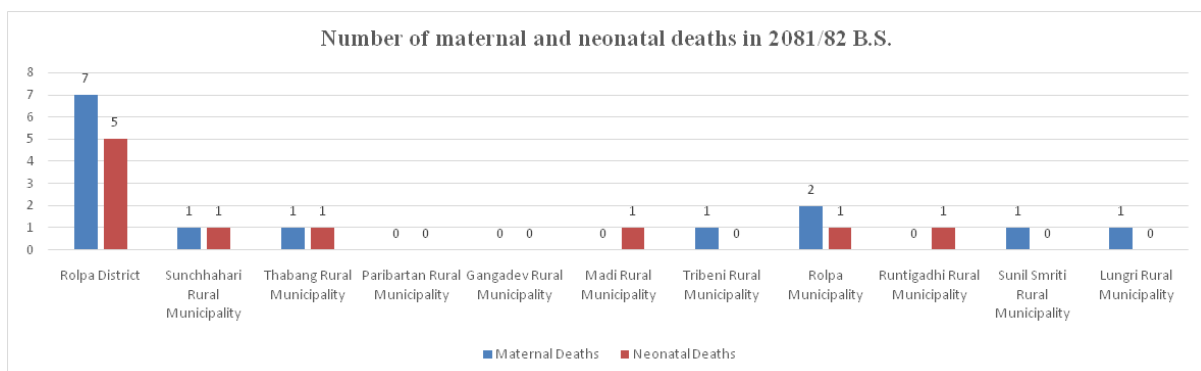
1. A skilled health provider (SHP) or skilled birth attendant (SBA) for deliveries that take place in a facility.
2. Early identification and treatment of complex cases, followed by referral to a medical facility offering round-the-clock emergency obstetric care (after administering obstetric first aid)
3. Maternal death and neonatal birth and death registration

#### a. Palika-wise distribution of proportion of Institutional Delivery and its proportion by SBA and SHP



The percentage of institutional delivery was 68.19% in fiscal year 2081/82 in Rolpa district, with the highest in Rolpa Municipality (90%) and lowest in Thabang Rural Municipality (55.53%). Similarly, the percentage of institutional delivery by trained SBA was 48.91% in fiscal year 2081/82 in Rolpa district, with the highest in Rolpa Municipality (70.21%) and lowest in Gangadev Rural Municipality (34.67%). Also, the percentage of institutional delivery by SHP was 3.46% in fiscal year 2081/82 in Rolpa district, with the highest in Sunil Smriti Rural Municipality (9.1%).

#### b. Palika-wise distribution of maternal and neonatal deaths in Rolpa District



There were a total of seven maternal and five neonatal deaths in fiscal year 2081/82 in Rolpa district, with the highest maternal deaths in Rolpa Municipality (2).

**Three-year Status of MPDSR in Rolpa district (FY 2079/80-2081/82)**

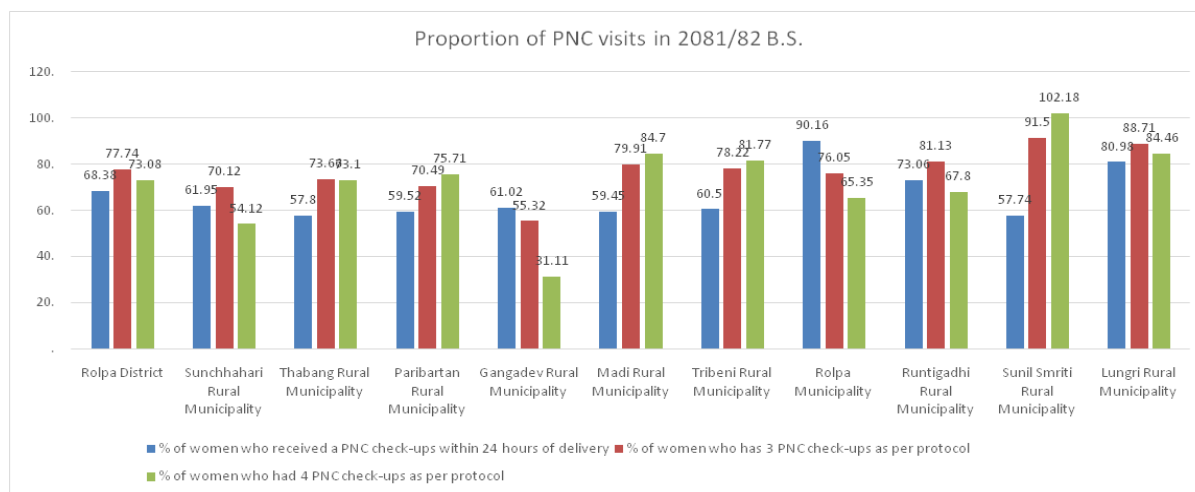
Name of LLG	FY 2079/80		FY 2080/81		FY 2081/82	
	Maternal death	VA done	Maternal death	VA done	Maternal death	VA done
Rolpa Mun	0	NA	0	NA	2	2
Sunchhahari	1	1	0	NA	1	1
Thawang	0	NA	0	NA	1	1
Paribartan	0	NA	0	NA	0	NA
Sukidaha	0	NA	0	NA	0	NA
Madi	1	1	0	NA	0	NA
Tribeni	0	NA	0	NA	1	1
Runtigadhi	1	1	0	NA	0	NA
Sunilsmriti	1	1	0	NA	1	1
Lungri	0	NA	0	NA	1	1
<b>Total</b>	<b>4</b>	<b>4</b>	<b>0</b>	<b>NA</b>	<b>7</b>	<b>7</b>

Verbal Autopsy (VA) was done for all the maternal deaths in fiscal year 2081/82 B.S. in Rolpa district.

**2.1.5.4 Palika-wise distribution of PNC visits**

Before FY 2078/79, mothers who had a minimum of three Post-Natal Care (PNC) visits were considered to have complete PNC check-ups. However, in FY 2079/80, the pNC protocol was revised, and a mother with four PNC check-ups was considered to have complete PNC check-ups. Postnatal care services include:

- Four postnatal visits: First visit within 24 hours of delivery, second visit on the third day and third visit on the seventh day, and fourth visit is 42 days after delivery.
- Identification and management of complications of the mother and newborn in the postnatal period and referral to the appropriate health facility as and when needed.
- Promotion of exclusive breastfeeding
- Personal hygiene and nutrition education, post natal vitamin A and iron supplementation for the mother
- Immunization of newborns
- Post natal family planning counseling and services



The percentage of women who received a PNC check-up within 24 hours of delivery was 68.38% in fiscal year 2081/82 in Rolpa district, with the highest in Lungri Rural Municipality (80.96%) and lowest in Sunil Smriti Rural Municipality (57.74%). Similarly, the percentage of women who had three PNC check-ups as per protocol was 77.74% in fiscal year 2081/82 in Rolpa district, with the highest in Sunil Smriti Rural Municipality (91.50%) and lowest in Gangadev Rural Municipality (55.32%). Also, the percentage of women who had four PNC check-ups as per protocol was 73.08% in fiscal year 2081/82 in Rolpa district, with the highest in Sunil Smriti Rural Municipality (102.18%) and lowest in Gangadev Rural Municipality (31.11%).

### 2.1.5.5 Reproductive Health Morbidity Service data in the Rolpa district, FY 2081/82

Uterine Cervical Cancer	HPV DNA, VIA, and Pap Smear & Others		
	Screened	Positive	
Number of females age group 30-49 years	1483	29	
Number of females $\geq$ 50 years	369	2	
<b>Breast Cancer</b>			
Screened	1168	Referred	0
Suspected	0	Surgery done	0
<b>Obstetric Fistula</b>			
Screened	411	Referred	0
Suspected	0	Surgery done	0
<b>Uterine Prolapse (No. of women)</b>			
Screened			1750
Diagnosed with prolapse	Stage 1 & 2	206	
	Stage 3	60	
	Stage 4	20	
Inserted Ring Pessary			208
Number of referred women			26
Treated with surgery			11

A total of 1483 females aged 30-49 years were screened for cervical cancer, of which 29 were positive cases, and of 369 e” aged 50 females screened females, 2 were positive cervical cases. A total of 1168 and 411 females were screened for breast cancer and obstetric fistula, respectively, and neither of them was suspected case. A total of 1750 females were screened for uterine prolapse, of which 280 were diagnosed with prolapse (206 were in stage one and two, 60 were in stage three, and 20 were in stage 4). Similarly, 208 women were treated by Ring Pessary, 26 women were referred to a higher center, and 11 women underwent surgery for uterine prolapse.

### **2.1.6 Major Activities under the MNH program in FY 2081/82**

- Purchase and supply of essential commodities to the birthing center for Quality Improvement
- One-day orientation was done for nursing staff about Antishock garments and their distribution to the health facility.
- ANC to PNC Continuum of care and PNC home visit program
- MPDSR orientation to the MPDSR stakeholders for LLG and HF Level staff, including others
- On-site coaching and mentoring on MNH services
- VIA test, STI management camps, screening and ring pessary service camp for uterine prolapsed clients, and timely referral for better management.
- Arranged Blood transfusion service for Aama Suraksha Program
- Supportive supervision and monitoring of the Program
- Provision of training like VIA, SBA, RUSG, CAC, etc
- Community awareness activities for the quality utilization of the birthing center and services
- Done two episodes of the Reproductive Health Coordination Committee (RHCC) meeting
- Referral mechanism strengthening program to the delivery service providers
- Coordinated with the Red Cross Society, District Chapter for blood during the delivery of pregnant mothers.

**2.1.7 Issues, Recommendations, and Responsibilities**

<b>Issues/Challenges</b>	<b>Recommendations</b>	<b>Responsibilities</b>
Inadequate supply of logistics, including power supply at Birthing Centers	Supply of adequate logistics (Equipment and Materials)	LLG
Less no. of SBA nurses and SBA deliveries	Provide SBA training to nurses working in birthing sites	HTC
Inadequate Health workforce (ANMs) at Birthing centers	Ensure 24-hour availability of adequate nursing staff in the Birthing sites	LLG
The inadequate use of some birthing centers and increasing the number of birthing centers, and increasing use of referral hospitals	Upgrade strategically located birthing centers to provide comprehensive quality primary health care services and aim for 'home delivery free' Wards.	HF, LLG
	Run innovative programs to encourage delivery at birthing centers.	
Poor referral practice	Develop a referral guideline that includes provisions for referral forms, as well as communication and feedback mechanisms.	HF, LLG

## 2.2 National Immunization Program

### 2.2.1 Introduction

Nepal's immunization history with the smallpox vaccine dates back much earlier than the late seventies. The first introduction of the smallpox vaccine in Nepal occurred in 1816, when the Nepalese government requested the British envoy for the vaccine. This early vaccination initiative was significant, although the king at the time died of smallpox. Smallpox control activities formally began in Nepal with help from the World Health Organization in 1962, and an eradication program started in 1967. Smallpox was officially declared eradicated in Nepal by the Nepali year 2034 BS (around 1977-1978 AD).

The National Immunization Program (NIP) was formerly started as the Expanded Program on Immunization (EPI) in 2034 B.S. and has been the priority program of the Government of Nepal (GoN). It has played a significant role in lowering the morbidity, mortality, and disability caused by diseases that can be prevented through childhood vaccination. The program offers free vaccination services against 13 pathogens, such as Tuberculosis, Diphtheria, Pertussis, Tetanus, Hepatitis B, Haemophilus influenzae type B, Polio, Rotavirus, Streptococcus Pneumoniae, Measles, Rubella, Japanese encephalitis (JE), and Typhoid. Nepal has planned to introduce the HPV vaccine in the upcoming FY 2081/82 as an effort to accelerate the elimination of cervical cancer. The country eliminated maternal and neonatal tetanus in 2005 and maintained its polio-free status since 2010 (regional certification in 2014) due to its strong immunization efforts. Even in rural locations, the program is accessible because of its wider network in health facilities, outreach clinics, and community health volunteers. Since FY 2069/70, Nepal's 'Full Immunization Declaration (FID)' initiative aims to combat social inequities, ensuring complete immunization for every child within administrative boundaries. As of Ashadh 2081, 76 districts have achieved and sustained 'full immunization' status. NIP will significantly contribute to achieving SDG 3 (Indicator 3.2.1 Under-five mortality rate and Indicator 3.2.2 Neonatal mortality rate) through a reduction in under-five child mortality. Nepal, the first country in the South-East Asia Region with the Immunization Act, 2072 B.S., the Immunization Regulation 2074 B.S., and the first country to adopt the "Full Immunization Declaration" Initiative.

NIP works closely with all three tiers of government. At the federal level, it works with other divisions of DoHS, national centers of MoHP, and supporting partners. At the Provincial level, the Health Directorate (HD) and its line agencies plan, execute, and monitor the various immunization programs. Provincial Health Logistic Management Center (PHLMC) executes the logistic plan, including storage and distribution of vaccine and vaccine-related commodities, including cold-chain management. At the local level, rural/municipal offices and their agencies are responsible for planning and implementation of immunization services through fixed clinics, outreach sessions, and mobile clinics.

The health office plays a critical role in NIP by coordinating and managing immunization service delivery at the local level. It oversees vaccine distribution, cold chain management, and the conduct of immunization sessions through fixed clinics, outreach sessions, and mobile clinics. The health office also works closely with FCHVs to ensure immunization coverage reaches all eligible children, including marginalized and hard-to-reach populations. It coordinates with government health facilities, private providers, and NGOs to deliver vaccines free of cost and supports microplanning and defaulter tracing to improve vaccination rates. Additionally, the health office plays a part in reporting immunization data and supporting capacity building for healthcare workers involved in immunization activities.

Since 2075/3/25(BS), Rolpa district has been declared fully immunization among the 0-15-month-old children and declaring its sustainability each year with the full participation of local stakeholders. A total of 222 Immunization clinics are providing vaccination services throughout the district, through trained vaccinators at fixed locations on the 15<sup>th</sup> to 20<sup>th</sup> day of every month. Besides this, Rolpa Hospital, Reugha provides immunization services to children 0-15 months child weekly in every Thursday, through the Mother and Child Health (MCH) clinic.

### **2.2.2 Guiding Documents of the National Immunization Program**

Alongside global (Immunization Agenda 2030: A Global Strategy to Leave No One Behind), regional (WHO's Regional Vaccine Implementation Plan 2022-2026), and national guiding documents like Comprehensive Multi-Year Plan (cMYP) 2017–2021, National Immunization Strategy (2023-2030) (draft version), aligned with the Nepal Health Sector Strategic Plan (2023-2030), will be the primary guiding documents for the NIP.

### **2.2.3 Vision, Mission, Goal, and Objectives of the National Immunization Program**

**Vision:** Nepal: a country free of vaccine-preventable diseases

**Mission:** To provide every child and mother with quality, safe, and affordable vaccines and immunization services from the National Immunization Program in an equitable manner.

**Goal:** Reduction of morbidity, mortality, and disability associated with vaccine-preventable diseases.

### Strategic Objectives

Objective 1: Reach every child for full immunization.

Objective 2: Accelerate, achieve, and sustain vaccine-preventable diseases control, elimination, and eradication.

Objective 3: Strengthen the immunization supply chain and vaccine management system for quality immunization services.

Objective 4: Ensure financial sustainability for the immunization program.

Objective 5: Promote innovation, research, and social mobilization activities to enhance best practices

### 2.2.4 Target Population of Rolpa District under the National Immunization Program

Particulars	Target Population	Vaccines
Under one year Children	4167	BCG, DPT-HepB-Hib, OPV, Rota, fIPV, PCV, and MR1 vaccine
12-23-month-old children	4025	JE, MR2, TCV
Total expected live births	4237	Tetanus Diphtheria (TD) vaccine

There were a total of 4167 under one-year-old children, 4025 12-23 months old children, and 4237 total expected live births in fiscal year 2081/82 in Rolpa district.

### 2.2.5 Vaccine Distribution Centers in the Rolpa District

Rolpa district has the following vaccine distribution centers to immunize the target populations in the district.

S.N.	Name of Local Level	Ward No.	Distribution Center (HF/LLG)
1.	Rolpa Municipality	4	Liwang HP
2.	Sunchhahari RM	5	Sunchhahari RM
3.	Thawang RM	1	Thabang RM
4.	Paribartan RM	1	Paribartan RM
5.	Gangadev RM	2	Jinawang HP
6.	Madi RM	2	Ghartigaun HP
7.	Tribeni RM	5	Gairigaun HP
8.	Runtigadhi RM	6	Holeri PHCC
9.	Sunilsmriti RM	4	Sulichur PHCC
10.	Lungri RM	5	Wadachour HP
	<b>Total</b>		<b>10</b>

There were a total of 10 vaccine distribution centers in the Rolpa district in the fiscal year 2081/82 B.S.

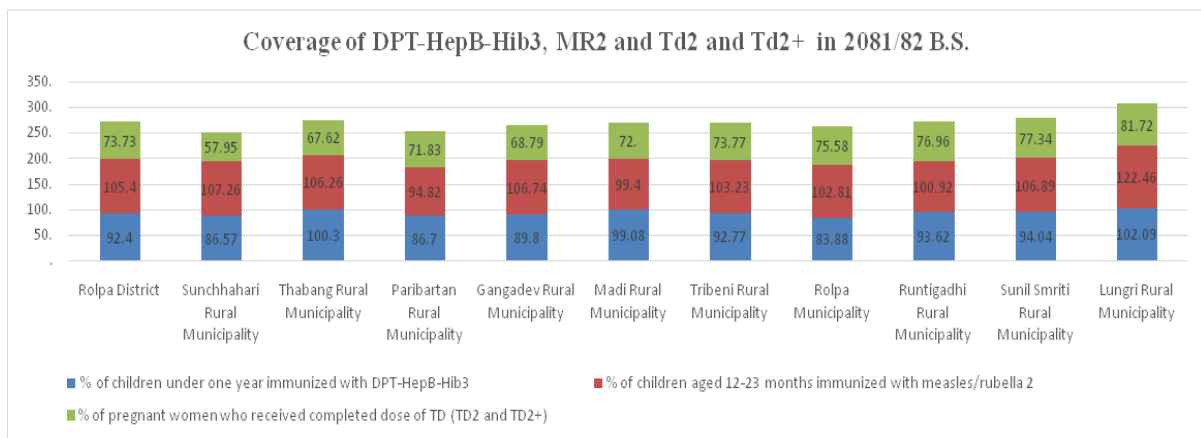
## 2.2.6 Indicators under the National Immunization Program in Rolpa District

### 2.2.6.1 Three-year trend of major Indicators under the National Immunization Program

S.N.	Indicators	Fiscal Years		
		2079/80	2080/81	2081/82
1	% of children under one year immunized with BCG	84	85	85
2	% of children under one year immunized with DPT-HepB-Hib1	90.12	91.51	91.78
3	% of children under one year immunized with DPT-HepB-HiB2	88.02	91.64	91.31
4	% of children under one year immunized with DPT-HepB-HiB3	87.3	92.57	92.4
5	% of children under one year immunized with OPV1	90.06	87.92	87.37
6	% of children under one year immunized with OPV2	91.51	91.62	92.57
7	% of children under one year immunized with OPV3	91.78	91.34	92.31
8	% of children under one year immunized with FIPV 1	78.74	92.34	92.16
9	% of children under one year immunized with FIPV 2	56.66	94.16	94.75
10	% of children under one year immunized with Rota 1	89.67	91.49	91.61
11	% of children under one year immunized with Rota 2	87.22	91.64	91.28
12	% of children under one year immunized with PCV 1	90.05	91.51	91.78
13	% of children under one year immunized with PCV 2	87.49	91.68	91.38
14	% of children under one year immunized with PCV 3	85.99	93.59	94.72
15	% of children under one year immunized with MR 1	85.95	93.53	94.8
16	% of children under one year immunized with MR 2	86.21	94.73	105.4
17	% of children immunized with TCV	86.23	94.93	105.33
18	% of children aged 12-23 months immunized with JE	84	97	102
19	% of pregnant women who received Td2 and Td2+	63	66	74
20	Dropout rate of DPT-HepB-Hib(1 vs 3)	3.13	-1.16	-0.68
21	Dropout rate of DPT-HepB-Hib1 vs MR2	4.23	-2.64	-10.93
22	Dropout rate of MR1 vs MR2	-0.42	-0.42	-7.4

The percentage of children under one year immunized with BCG is 85% in fiscal year 2081/82 B.S. in Rolpa district and has been constant since the last fiscal year. The coverage of DPT-HepB-Hib1 and DPT-HepB-Hib3 was 91.78% and 92.4% in fiscal year 2081/82 B.S. in Rolpa district. The coverage of OPV1 and OPV3 was 87.37% and 92.31% in fiscal year 2081/82 B.S. in Rolpa district. The coverage of FIPV1 and FIPV2 was 92.16% and 94.75% in fiscal year 2081/82 B.S. in Rolpa district. The coverage of Rota1 and Rota2 was 91.61% and 94.28% in fiscal year 2081/82 B.S. in Rolpa district. Similarly, the coverage of PCV1 and PCV3 was 91.78% and 94.72% in fiscal year 2081/82 B.S. in Rolpa district. Likewise, the coverage of MR1 and MR2 was 94.5% and 105.4% in fiscal year 2081/82 B.S. in Rolpa district. The percentage of children who received TCV, JE, and pregnant women who received Td2 and Td2+ was in an increasing trend and was 105.33%, 102% and 74% respectively, in fiscal year 2081/82 B.S. in Rolpa district. The dropout rate of DPT-HepB-Hib(1 vs 3), DPT-HepB-Hib1 vs MR2, and MR1 vs MR2 was -0.68%, -10.93% and -7.4% respectively, in fiscal year 2081/82 B.S. in Rolpa district.

### 2.2.6.2 Palika-wise coverage of DPT-HepB-Hib3, MR2 and Td2 and Td2+ in FY 2081/82



The percentage of pregnant women who received a completed dose of TD was 73.73% in Rolpa district in fiscal year 2081/82 B.S., with the highest percentage in Lungri Rural Municipality (81.72%) and the lowest percentage in Sunchhari Rural Municipality (57.95%). Similarly, the percentage of children under one year immunized with DPT-HepB-Hib3 was 92.40% in Rolpa district in fiscal year 2081/82 B.S., with the highest percentage in Lungri Rural Municipality (102.09%) and the lowest percentage in Rolpa Municipality (83.83%). Likewise, the percentage of children aged 12-23 months immunized with Measles-Rubella 2 was 105.4% in Rolpa district in fiscal year 2081/82 B.S., with the highest percentage in Lungri Rural Municipality (122.09%) and the lowest percentage in Paribartan Rural Municipality (94.82%).

### 2.2.6.3 Palika-wise dropout rate in FY 2081/82

Dropout in the immunization program indicates the utilization and the rate within an acceptable limit (-10 to 10) is expected to ensure good utilization of services; higher dropout rates signify that there could be problems with recording and reporting, or because of the miscalculated denominators.

Name of LLG	DPT-HepB-Hib 1 vs 3	DPT-HepB-Hib1 vs MR2	Measles/rubella 1 vs 2
Sunchhahari RM	1.19	-18.18	-13.26
Thabang RM	-10.83	-14.01	-5.92
Paribartan RM	-2.52	-9.43	-1.75
Gangadev RM	1.85	-12.7	-3.65
Madi RM	-2.68	-0.33	-1.69
Tribeni RM	2.27	-4.29	-2.74
Rolpa M	-2.01	-20.48	-18.34
Runtigadhi RM	2.00	-1.60	-1.80
Sunil Smriti RM	-2.12	-12.36	-9.81
Lungri RM	-0.19	-15.67	-10.54
<b>Rolpa District</b>	<b>-0.68</b>	<b>-10.93</b>	<b>-7.40</b>

The dropout rate for DPT-HepB-Hib-1 vs. DPT-HepB-Hib-3, DPT-HepB-Hib-1 vs. MR2, and MR1 vs MR2 was -0.68%, -10.93% and -7.4% respectively in Rolpa district in fiscal year 2081/82 B.S.

### 2.2.6.4 Categorization of Palika based on access and utilization of Immunization in FY 2081/82

The National Immunization Program (NIP) also evaluates the status of the accessibility and utilization of immunization services. Local levels are categorized by Category 1 to Category 4 based on DPT-HepB-Hib1 coverage and dropout rate of DPT-HepB-Hib1 VS MR2 to know the accessibility and utilization of immunization services, respectively.

Rolpa district, with 92.4% coverage of DPT-HepB-Hib1 and a -10.93% dropout rate of DPT-HepB-Hib1 VS MR2 in fiscal year 2081/82 B.S., Rolpa district falls under Category II [High Coverage (e"90%), High Dropout (e"10%)].

Category I (fewer problems)	Category II (Problem)	Category III (Problem)	Category IV (Problem)
High Coverage (≥90%) Low Drop-Out (<10%)	High Coverage (≥90%) High Dropout (≥10%)	Low Coverage (<90%) Low Dropout (<10%)	Low Coverage (<90%) High Dropout (≥10%)
<ul style="list-style-type: none"> <li>• Madi Rural Municipality (Coverage: 99.03%, Dropout: -0.33%)</li> <li>• Tribeni Rural Municipality (Coverage: 92.77%, Dropout: -4.29%)</li> <li>• Runtigadhi Rural Municipality (Coverage: 93.62%, Dropout: -1.60%)</li> </ul> <p style="text-align: center;"><b>(3 Local Levels in Rolpa District)</b></p>	<ul style="list-style-type: none"> <li>• Thabang Rural Municipality (Coverage: 100.03%, Dropout: -14.01%)</li> <li>• Sunil Smriti Rural Municipality (Coverage: 94.04%, Dropout: 12.30%)</li> <li>• Lungri Rural Municipality (Coverage: 102.09%, Dropout: -15.67%)</li> </ul> <p style="text-align: center;"><b>(3 Local Levels in Rolpa District)</b></p>	<ul style="list-style-type: none"> <li>• Paribartan Rural Municipality (Coverage: 86.7%, Dropout: -9.43%)</li> </ul> <p style="text-align: center;"><b>(1 Local Level in Rolpa District)</b></p>	<ul style="list-style-type: none"> <li>• Sunchhari Rural Municipality (Coverage: 86.57%, Dropout: -18.18%)</li> <li>• Gangadev Rural Municipality (Coverage: 89.8%, Dropout: -12.70%)</li> <li>• Rolpa Municipality (Coverage: 83.33%, Dropout: -20.48%)</li> </ul> <p style="text-align: center;"><b>(3 Local Levels in Rolpa District)</b></p>
<p>*All local levels, as well as the district, have been declared and sustained as a fully immunization district</p>			

Reviewing the overall local level, Madi Rural Municipality, Tribeni Rural Municipality and Runtigadhi Rural Municipality of the Rolpa district are in Category I (having good accessibility and utilization of immunization services); Thabang Rural Municipality, Sunil Smriti Rural Municipality and Lungri Municipality are in Category II (having good accessibility and poor utilization of immunization services); Paribartan Rural Municipality is in Category III (having poor accessibility and high utilization of immunization services) & Sunchhari Rural Municipality, Gangadev Rural Municipality and Rolpa Municipality in Category IV (having poor accessibility and poor utilization of immunization services).

### 2.2.6.5 Vaccine wastage rate in FY 2081/82

The benchmark for vaccine wastage rate at the national level is shown below.

Name of Antigen	BCG	JE	MR	DPT-HepB-Hib	PCV	fIPV	bOPV	Rota	TCV	Td
National standard	50%	40%	33%	15%	5%	10%	15%	5%	10%	15%

The vaccine wastage rate in Rolpa District and at its local level is shown below.

Vaccine Wastage in Rolpa District in FY 2081/82 B.S.										
Organization Unit	BCG	DPT/He pB/Hib	FIPV	JE	MR	OPV	Rota	TCV	TD	PCV
Sunchhahari R M	90.13	36.81	45.03	59.23	65.88	38.36	4.20	38.13	60.91	18.51
Thabang R M	89.08	35.85	43.93	58.22	68.07	35.60	0.00	38.49	57.56	16.53
Paribartan R M	84.62	20.08	31.49	45.85	54.30	20.73	0.46	23.52	30.00	8.92
Gangadev R M	83.90	22.71	24.81	37.87	46.69	24.29	0.00	29.00	37.8	10.48
Madi R M	86.88	24.17	34.92	46.06	53.88	24.79	1.79	33.78	43.79	10.02
Tribeni R M	86.18	25.77	35.59	50.31	58.63	26.24	-0.13	31.74	40.23	9.21
Rolpa M	88.76	31.68	41.05	56.28	62.22	31.51	0.80	34.32	40.13	15.54
Runtigadhi R M	89.02	27.08	36.68	55.80	62.63	28.5	0.71	38.15	38.47	13.61
SunilSmriti R M	87.82	23.43	35.03	47.72	58.81	22.29	0.86	27.7	33.47	9.76
Lungri R M	84.91	17.34	27.47	37.85	47.27	19.90	1.05	23.33	23.94	7.24
<b>Rolpa District</b>	<b>87.33</b>	<b>25.95</b>	<b>35.29</b>	<b>49.64</b>	<b>58.02</b>	<b>26.66</b>	<b>0.91</b>	<b>31.48</b>	<b>39.42</b>	<b>11.62</b>

The vaccine wastage rates are above the national benchmark in Rolpa district in fiscal year 2081/82 B.S., except the Rota vaccine, which has a vaccine wastage rate of 0.91% below the national benchmark (5%). Based on the data verification, physical damage, label loss, incomplete use of the nominal number of doses in multi-dose vials, expiration before use, and not maintaining the temperature for both heat and freeze-sensitive vaccines are all common reasons for higher vaccine wastage.

### 2.2.6.6 HPV vaccination campaign in FY 2081/82

The HPV vaccine was introduced in Nepal in FY 2081/82 as an effort to accelerate the elimination of cervical cancer, targeting girls in grades 6 and 10-year-old adolescent girls who don't go to school. The HPV vaccine campaign was conducted throughout the Rolpa district since 22 magh 28 magh 2081. 296 Clinics were conducted for HPV vaccination, especially in schools and Health Facilities.

		स्वास्थ्य कार्यालय, रोल्पा							
		एच.पि.भी. खोप अभियान २०८१ दैनिक प्रगति प्रतिवेदन							
स्थानीय तह	अनुमानित लक्षित संख्या	खोप लगाएको जम्मा सङ्ख्या (माघ २२ देखि २८ सम्म)							प्रगत प्रतिशत
		२२ गते	२३ गते	२४ गते	२५ गते	२६ गते	२८ गते	जम्मा	
सुनछहरी गाउँपालिका	९१३	६००	१७९	७८	४३	०	२	९०२	९९
थवाङ गाउँपालिका	५०१	२६८	२१६	७	११	९	०	५११	१०२
परिवर्तन गाउँपालिका	९७५	२५६	३०१	२८४	१०२	१७	१५	९७५	१००
गंगादेव गाउँपालिका	१५२१	४८६	४७१	४६०	११४	०	०	१५३१	१०१
माडी गाउँपालिका	८७३	३३०	१५७	३०८	३०	३२	३३	८९०	१०२
त्रिवेणी गाउँपालिका	१३०२	४९३	२३८	४१९	१०४	२५	२१	१३००	१००
रुन्टीगढी गाउँपालिका	१५३०	७४७	३७०	२४३	४६	६	९	१४२१	९३
रोल्पा नगरपालिका	१९४५	९१९	५३२	३८८	९४	१३	१४	१९६०	१०१
सुनिलस्मृति गाउँपालिका	१८२४	५४५	४५१	३८२	१०३	८५	७४	१६४०	९०
लुंग्री गाउँपालिका	१६२०	५७६	५४७	२०८	१८९	२८	१०१	१६४९	१०२
रोल्पा जिल्ला जम्मा	१३००४	५२२०	३४६२	२७७७	८३६	२१५	२६९	१२७७९	९८

The percentage of eligible candidates who were given the HPV vaccine in Rolpa district in fiscal year 2081/82 B.S. was 98% with the highest percentage in Thabang and Lungri Rural Municipality (102%) and the lowest percentage in Sunil Smriti Rural Municipality (90%).

### **2.2.7 Major activities carried out in Rolpa district in FY 2081/82 under NIP**

1. Round yearly management and supply of the vaccines and related commodities for the uninterrupted conduct of NIP sessions, clinics, and hygiene promotion sessions
2. Basic Immunization Training for Health Workers
3. Declaration of Full Immunization Sustainability of the district, local level, and ward, followed by line-listing and household survey
4. Supply for cold chain equipment and related logistics commodities to all distribution centers
5. Repair and maintenance of cold chain equipment's
6. Conducted vaccination campaign against COVID-19 regularly at the ward level in the different phases
7. Prepare, publish, and distribute of Immunization microplanning booklets, Immunization diary, vaccine monitoring sheets, Immunization card, and necessary forms and formats related to the national immunization program.
8. Orientation on introduction of Covid-19 vaccine, AEFI, and its management to all Health Workers, vaccinators, including FCHV.
9. Conducted the district-level immunization coordination committee meeting semi-annually
10. Conducted the Measles-Rubella and IPV campaign throughout the district
11. Orientation regarding the Immunization Act and regulations for the health workers and stakeholders
12. Conduction of District, Municipal, and health facility level immunization review meetings and micro planning preparation workshop
13. Data verification and quality monitoring of low/poor immunization coverage sites
14. Celebration of the Baisakh month as the immunization month to decrease dropout rates and sensitization to the public.
15. Expansion of zero reporting sites of VPD Surveillance in all palikas
16. Supportive monitoring and supervision visits to health facilities and at the community level
17. Conducted awareness and COVID-19 vaccination campaigns through school and community outreach, stakeholder coordination meetings, regular IEC/BCC media activities, and systematic recording and reporting.

### 2.2.8 Issues, Recommendations, and Responsibilities

Issues/Challenges	Recommendations	Responsibilities
Program duplication in the district and at the Municipal level	Avoid the duplication of the program	MoHP/DOHS/MOH
	Coordination with the Palikas for an overview of the program activities and sharing	HO and LLG
The provision of compensation for field activities is not uniform for all staff.	Provision of compensation for field activities should be provided equally for all staff.	MoHP/DOHS/ MoF/MOH
Inadequate budget for vaccine transportation at the local level	Properly allocate the budget for vaccine transportation as per need	MoH, FWD, DoHS
There is no electricity backup system around the year	Provision of electricity backup in the district cold chain store and vaccine and distribution center	MoHP/DOHS/ MoF/MOH
Poor quality immunization data with under- and over-reporting	Enhance the supportive supervision of lower levels and the DQSA program	HF, HO, HD, FWD

## 2.3 Integrated Management of Neonatal and Childhood Illnesses

### 2.3.1 Introduction

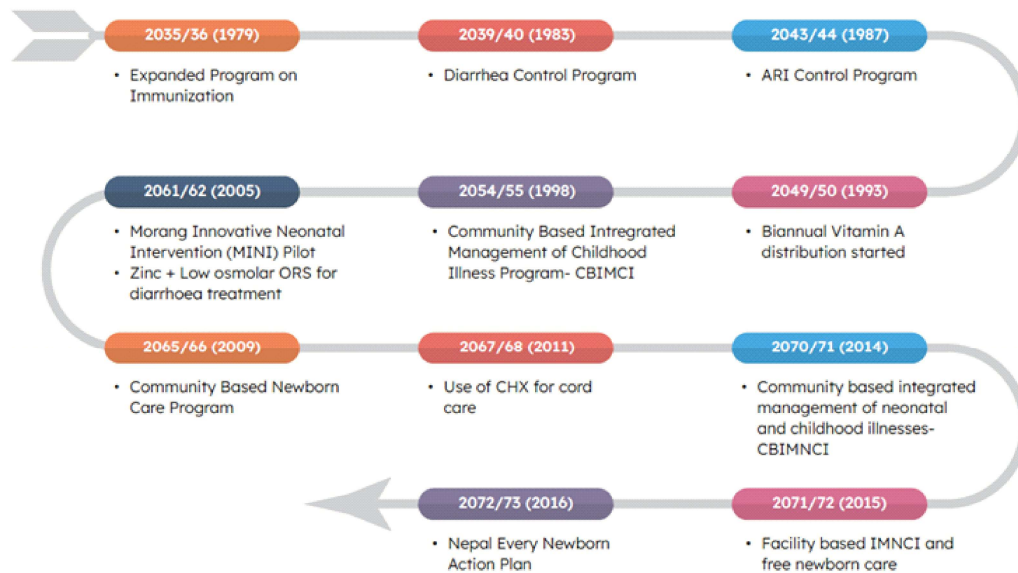
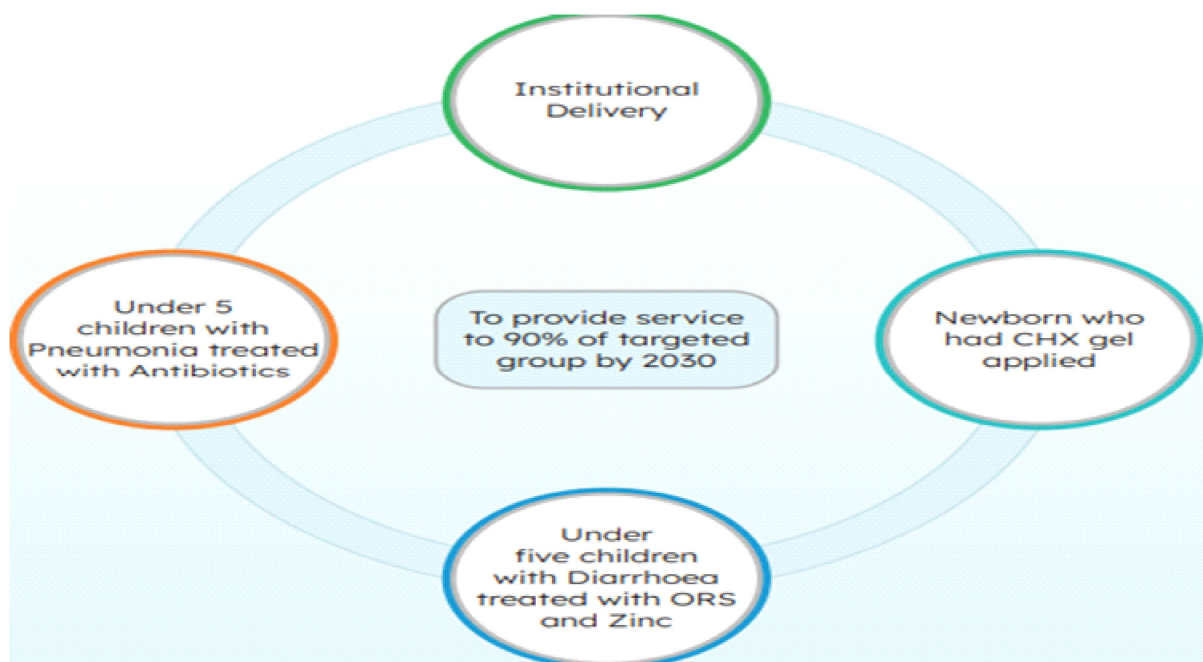


Figure 1: Development of the Integrated Management of Neonatal and Childhood Illnesses program in Nepal

Child survival intervention began in Nepal in 1983 with the initiation of the Control of Diarrheal Disease (CDD) Program and the Acute Respiratory Infection (ARI) Control Program in 1987. In 1997/98, the ARI intervention was combined with CDD and named as CB-AC (Community-Based ARI and CDD) program. One year later, two more components, nutrition and immunization, were incorporated into the CB-AC program. The Integrated Management of Childhood Illness (IMCI) program was piloted in the Mahottari district and was extended to the community level as well. Finally, the government decided to merge the CBAC into IMCI in 1999 and named it as Community-Based Integrated Management of Childhood Illness (CB-IMCI), as both programs targeted the same population with involvement of similar Health Service Providers. After successful piloting of low-osmolar ORS and Zinc supplementation, it was incorporated into the CB-IMCI program in 2005. The Community-Based Newborn Care Program (CB-NCP) was designed in 2007 and piloted in 10 districts. In 2009, CB-NCP was implemented nationwide. In 2011, CHX (Chlorhexidine) was used for cord care. In 2014, Community-Based Integrated Management of Neonatal and Childhood Illness (CB-IMNCI) was initiated. In 2015, the Family-Based (FB) IMNCI and free newborn care program was initiated.

FB-IMNCI addresses gaps in managing cases referred from peripheral health institutions. Linked with CB-IMNCI, it uses Emergency Triage and Treatment (ETAT) at health facilities. The thematic approach covers newborn care, cough, diarrhea, fever, malnutrition, and anemia. The goal is to equip district hospital teams for effective management of complicated under-five and neonatal cases. The CB-IMNCI program has the vision to provide targeted services to 90% of the estimated population by 2030, as shown in the diagram guided by Vision 90 by 30 (Fig...).



*Figure 2: Vision of Integrated Management of Neonatal and Childhood Illnesses of Nepal*

The program aims to address major childhood illnesses like Pneumonia, Diarrhea, Malaria, Measles, and Malnutrition among children under 5 years in a holistic way. It is reported to contribute to reducing the prevalence of pneumonia and diarrhea significantly. Nepal has implemented both the community-based and facility-based IMNCI approaches. In the CB-IMNCI program, FCHVs are expected to carry out health promotional activities for maternal, newborn, and child health and dispensing of essential commodities like distribution of iron, zinc, ORS, chlorohexidine, and immediate referral in case of any danger signs appearing among sick newborns and children. Health workers will counsel and provide the health service, like management of non-breathing cases, skin-to-skin contact, and management of neonatal sepsis and common childhood illnesses. In addition, the program has provisioned the post-natal visits by trained health workers through the primary health care outreach clinic.

Child Health & Immunization Services Section concentrates on monitoring, supportive supervision, onsite coaching, and RDQA to enhance the CBIMNCI program. This initiative is geared towards reaching unreached populations and communities by implementing the Equity and Access Program (EAP). The health-care seeking behavior and practices have been improved at the household level. In FY 2079/80, the treatment chart booklet was revised as per WHO updates to aid health workers in classifying, treating, and managing childhood diseases classified as up to two months and two months to five years old children.

### **2.3.2 Goals, objectives, strategies, targets, and major interventions of IMNCI and Newborn Care program**

**Goal:** Improve Newborn child survival and ensure healthy growth and development.

**Objectives:**

1. To reduce neonatal morbidity and mortality by promoting essential Newborn care services & managing major causes of illness
2. To reduce morbidity and mortality by managing major causes of illness among children under 5 years

**Strategies:**

1. Quality of care through system strengthening and referral services for specialized care
2. Ensure universal access to health care services for newborns and young infants
3. Capacity building of health service providers and FCHVs
4. Increase service utilization through demand generation activities
5. Promote decentralized and evidence-based planning and programming

**Targets:**

<b>Indicators (Per 1000 live births)</b>	<b>Status as per the NDHS 2022 of Nepal</b>	<b>SDG 2030 of Nepal</b>
Neonatal Mortality Rate (NMR)	21	At least as low as 12
Stillbirths	17	At least as low as 12.5
Under-five Mortality Rate	33	At least as low as 25

**Major Interventions:**

**a. Newborn Specific Interventions**

1. Promotion of the birth preparedness plan
2. Promotion of essential newborn care practices and postnatal care to mothers and newborns
3. Identification and management of shortness of breath in babies at birth
4. Identification and management of preterm and low birth weight babies
5. Management of sepsis among young infants (0-59 days), including diarrhea

**b. Child Specific Interventions**

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

**c. Capacity building/enhancement & quality assurance**

- On-site Coaching (guidelines development /revision, coach development, and coaching & mentoring for Routine Data Quality Assessments)

**d. Cross-Cutting Interventions**

- Promote the behavior change communications for a healthy pregnancy, safe delivery, and promote personal hygiene and sanitation.
- Improved the knowledge regarding the immunization, nutrition, and care of sick children,
- Improved the interpersonal communication skills of HWs and FCHVs,
- Increased community participation through the Equity and Access Program (EAP)

### 2.3.3 Major Indicators

Indicators	2079/80	2080/81	2081/82
% of children under five years enrolled in the IMNCI program	110.06	134.78	153.41
ARI Incidence Rate among children < 5 years Children	728	770	869
% of Pneumonia	24	23	20
% of Pneumonia among children < 5 years treated with antibiotics (Amoxicillin)	100	100	100
Incidence of Diarrhoea/1000 < 5-Year Children	208	251	261
% of children under five years with diarrhoea suffering from Severe dehydration	0	0	0
% of Diarrhoea Cases Treated by ORS and Zinc	100	100	100
Deaths due to diarrhoea	0	0	0
<b>Neonatal Indicators</b>			
% of infants aged 0-2 months with Local Bacterial Infection	32.5	29.2	28.38
% of infants aged 0-2 months with PSBI	9.45	7.74	6.18
% of infants aged 0-2 months with PSBI receiving a first dose of Gentamycin	96.49	98.25	102.13
% of infants aged 0-2 months with PSBI receiving a complete dose of Gentamycin	57.9	57.9	53.19
% of newborns to whom chlorhexidine (CHX) gel was immediately applied among reported live births	99	100	100

The percentage of newborns to whom chlorhexidine (CHX) gel was immediately applied among reported live births was 100% in 2081/82 and the last fiscal year. The proportion of children under five years enrolled in the IMNCI program was on an increasing trend in the last three years and was 153.41% in fiscal year 2081/82 B.S. in Rolpa district. The ARI incidence rate among Under-5 years children was also in an increasing trend and was 869 per 1000 population, and 20% of them were pneumonia cases in fiscal year 2081/82 B.S. The percentage of pneumonia cases among under-five years children treated with amoxicillin was 100% in the last three fiscal years. Similarly, the incidence of diarrhea among Under-5 years children was also in an increasing trend and was 261 per 1000 population, and 0% of them were diarrhea sufferers from severe dehydration in fiscal year 2081/82 B.S. in Rolpa district. The percentage of diarrhea cases among under-five years children treated with ORS and zinc was 100% in the last three fiscal years.

### 2.3.4 Major Activities

The major activities carried out by HO, Rolpa, in FY 2081/82 under IMNCI and Newborn Care program were:

- IMNCI training was done for health workers (paramedics and nurses)
- District-level CB-IMNCI review and data verification were done at the health facility level
- Regular data review, analysis, interpretation, and presentation of the program to enhance the quality of recording and reporting
- Regular supply of the IMNCI commodities at the health facility level
- Supportive supervision and monitoring of the program

### 2.3.5 Issues, Recommendations, and Responsibilities

Issues/Challenges	Recommendations	Responsibilities
Inadequate Logistic supplies, like job aids, treatment books, treatment cards, timers, etc., from the central level	Provision of a regular logistics supply	FWD, PHLMC
Poor recording and reporting as per guidelines	Maintain the CB-IMCI register properly at HF, and discuss with FCHV about recording and reporting as per the guidelines.	HO, LLG, HF
Poor referral mechanism	Strengthen the referral mechanism	HO/HF/LLG
Lack of CBIMNCI-trained health workers in health facilities	Provision of training regularly	MoH/HTC
Low coverage & quality of health care	Strengthen the quality improvement system through enhanced use of health facility tools (registers and DHIS-2), onsite coaching, and supportive supervision and mentoring.	HD/HO/LLG/HF

## 2.4 Nutrition Program

### 2.4.1 Introduction

Nutritional interventions have been proven to improve human capital through increased productivity and are very cost-effective for socioeconomic development. Nutrition is a globally recognized development agenda. Since the year 2000, several global movements have advocated nutrition for development. The Scaling-Up-Nutrition (SUN) initiative calls for multi-sectoral action for improved nutrition during the first 1,000 days of life. The GoN, as an early member of SUN, adopted the Multi-Sector Nutrition Plan (MSNP) in 2012 to reduce chronic nutrition (first phase implemented for 2013-2017, the second phase during 2018-2022, and the third phase during 2023-30). The UN General Assembly declared the 2016-2025 period as the Decade of Action on Nutrition.

Though the Constitution of Nepal (2015) guarantees all citizens the right to food, health, and nutrition, Malnutrition is a significant public health problem in Nepal, with malnutrition rates ranking among the highest in the South Asia region. Between FY 2052/53 and FY 2080/81, Nepal made significant strides in reducing severe stunting and wasting in children under five, dropping from 57% to 25% and from 15% to 8%, respectively. However, challenges persist, with a 19% prevalence of underweight among children less than five years old. Anemia remains a major concern, affecting 43% of children under five and 23.1% of women aged 15-49. Of particular concern is the 6–23-month age range, where over 65.7% of children have anemia.

The overall nutrition program is guided by the National Nutrition Strategy 2077 (2077-2087 B.S./2020-2030 A.D.), which has been revised and updated as per the federal structure and is based on the provisions of the existing National Health Policy 2076. Policy no. 6.13 of the National Health Policy 2076 B.S. highlights improved nutrition via the use and promotion of quality and nutritious foods produced locally to fight malnutrition.

Improving the nutritional status of the people in Nepal is a major responsibility of the Nutrition Section of the Family Welfare Division (FWD), Department of Health Services (DoHS). The nutrition section focuses especially on vulnerable populations such as marginalized communities, pregnant and lactating women, the elderly, and children under five. Implementing national nutrition policy and coordinating with the Ministry of Health and Population (MoHP) to include nutrition-specific and nutrition-sensitive initiatives into the health system are among its duties. Under the Multi-Sector Nutrition Plan III (MSNP 2023-2030), the section supports multi-sectoral activities by designing and managing interventions to address micronutrient deficiencies, stunting, wasting, and malnutrition. It assures the efficacy of interventions and makes the required modifications by routinely monitoring and assessing important

nutrition parameters. The unit also ensures timely purchase and distribution of key nutrition commodities, including micronutrient powders, vitamin A, iron, and folic acid supplements, and therapeutic foods. It places a strong emphasis on behavior change communication (BCC) initiatives that engage the community, raise knowledge of healthy eating habits, and motivate proactive community involvement for long-lasting gains.

Along with the federal Government, the provincial government has established a high-level commitment and prioritized nutrition programs to enhance the nutritional status of Lumbini province's children, pregnant women, breastfeeding mothers, and adolescents. The Ministry of Health and the Health Directorate (HD) are responsible for providing nutrition services throughout the province in cooperation and collaboration with the federal government and local levels, as well as development partners. The health office acts as the key operational body at the district and local levels, driving nutrition program activities, capacity building, collaboration, monitoring, and advocacy to improve nutrition outcomes in Nepal.

#### **2.4.2 Vision, Goal, Objectives, and Outcomes of Multi-sectoral Nutrition Plan 2023-2030**

**Vision:** Ending malnutrition, building human capital, and overall socio-economic development

**Goal:** To improve nutritional status throughout the human life cycle by ensuring the availability and accessibility of quality nutrition services

**Objectives:**

1. Ensure equitable access and consumption by improving the availability and quality of nutrition-specific services.
2. Ensure equitable access and consumption by improving the availability and quality of nutrition-sensitive services.
3. To enhance the engagement, accountability, and institutional capacity of the three tiers of government and stakeholders to institutionalize nutrition-friendly systemic approaches.
4. Promote good practices related to health, nutrition, and water, sanitation, and hygiene through social behavior change.

**Outcome:**

1. Equitable access to and improved utilization of quality nutrition-specific services.
2. Equitable access to and consumption of quality nutrition-sensitive services and adequate consumption of safe, healthy, and nutritious food.
3. Nutrition-friendly systemic approaches are institutionalized across the three levels of government.
4. Positive changes in knowledge, attitudes, and practices related to health, nutrition, drinking water, sanitation, and hygiene.

**2.4.3 Key strategies**

The key strategic areas of the National Nutrition Strategy 2077 are: -

1. Multi-sectoral nutrition policy and programs, including food security, will be updated and implemented with high priority.
2. Short-term, medium-term, and long-term measures will be adopted at all levels with emphasis on food diversification and a balanced diet to improve the micronutrition status of different age groups, including women and children.
3. Programs will be developed and operated by strengthening school health programs and nutrition education.
4. Domestic production will be promoted by encouraging the consumption of various nutritious and healthy foods.

**2.4.4 Targets and status**

SN	Global nutrition targets for 2030	National Status as per NDHS 2022	Nepal's SDG targets-2030
1.	Stunting among U5 children	25%	15%; (17% <sup>a</sup> ) (4% <sup>b</sup> )
2.	Wasting among U5 years children	8%	4%
3.	Underweight among U5 years children	19%	10%
4.	Anemia among U5 years children	43%	<15%
5.	Anemia among 2-year-old children	31.3%	<50%
6.	Anemia in 15-49 years women	34%	<25%
7.	BMI (<18.5kg/m <sup>2</sup> ) among women aged 15-49	10% (among 20-49-year-old women)	<5%
8.	Anemia among pregnant women	32.7%	<25%

*a=target for stunting among U5 children as per the sixteenth five-year plan (2024-2029)*

*b=target for stunting among U5 children as per Second Five-Year Plan (2081/82-2085/86 B.S.) of Lumbini Province*

## 2.4.5 Indicators of Nutrition Program

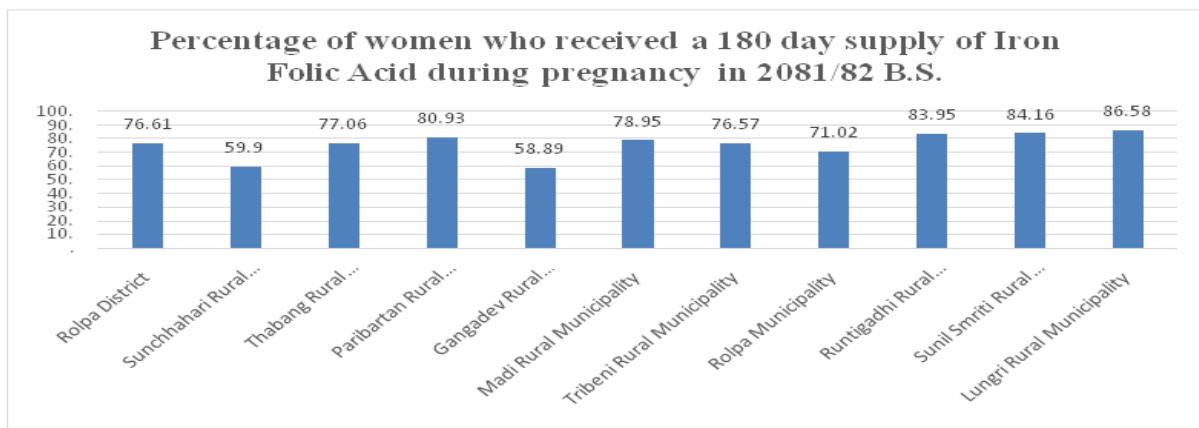
### 2.4.5.1 Three-year trend of major indicators of the Nutrition Program

Indicators	Fiscal years		
	2079/80	2080/81	2081/82
Number of SAM cases (6-59 months) admitted to outpatient therapeutic centers (OTCs)	44	56	26
Number of MAM cases(6-59 months) admitted to OTCs	62	40	28
% of children aged 6-59 months who received Vitamin A supplementation in the last six months	88.07	96.72	110.69
Number of <5 years children receiving deworming tablets	38262	35598	34843
% of 0-11 months aged children newly registered for Growth Monitoring	90.7	94	97.88
% of 12-23-year-old children newly registered for Growth Monitoring	7.1	3.8	3
Average number of visits among 0-23 months aged children for growth monitoring	14	17	20
% of 0-23 months aged children registered and visited for Growth Monitoring who were underweight	1.6	1.3	1.2
% of Children below 6 months exclusively breastfed among those registered for growth monitoring,	65.97	81.64	83.32
% of children aged 6-8 months registered for growth monitoring who received solid, semi-solid, or soft foods	66.8	80.6	83.9
% of postpartum women who received Vitamin A supplementation	98.3	98.6	104.5
% of women who received a 180-day supply of Iron Folic Acid during pregnancy	64.9	69.4	76.6
% of postpartum women who received a 45-day supply of IFA	98.8	98.7	100.6

The percentage of women who received a 180-day supply of Iron Folic Acid during pregnancy was in an increasing trend and was 76.6% in fiscal year 2081/82 in Rolpa district. The percentage of postpartum women who received a 45-day supply of IFA was 100.6% in fiscal year 2081/82 and was higher than in the last fiscal year. Similarly, the percentage of 0-11 months aged children newly registered and visited for Growth monitoring was in increasing trend since the last three fiscal years and was 97.88% in fiscal year 2081/82, and for 12-23 months was in decreasing trend and was 3% in fiscal year 2081/82 in Rolpa district. Likewise, the percentage of children below six months who were exclusively breastfed among those registered for growth monitoring was in an increasing trend and was 83.32% in fiscal year 2081/82 B.S.

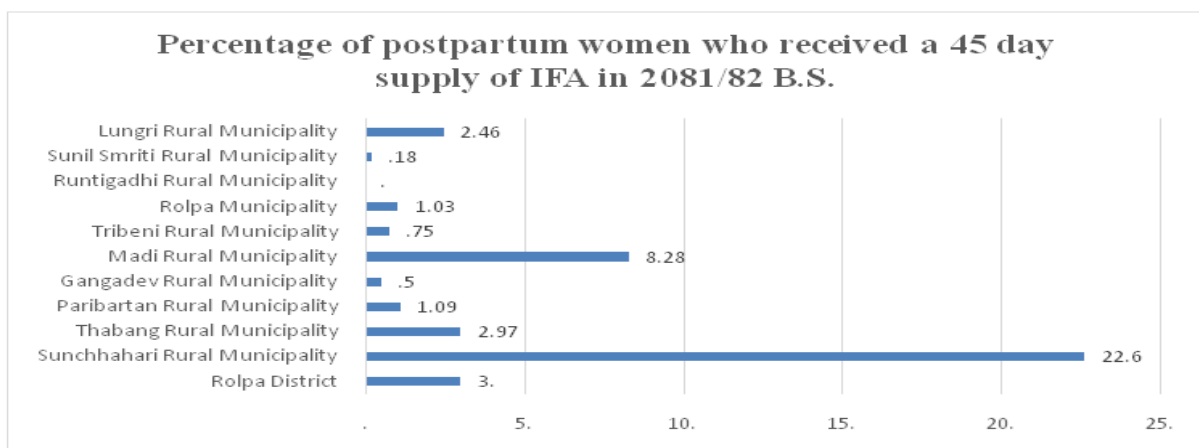
**2.4.5.2 Palika-wise distribution of Iron Folic Acid consumed by women during pregnancy**

Since 1998, the MoHP has been providing Iron Folic Acid (IFA) at “no cost” to pregnant women and breastfeeding mothers through the HF, PHC/ORC, and FCHVs as part of ANC and PNC services. Pregnant women are provided with 180 tablets during ANC visits and are advised to take one tablet a day. An additional 45 tablets are provided after childbirth to cover the post-partum period. An additional 45 tablets are provided after childbirth to cover the post-partum period.



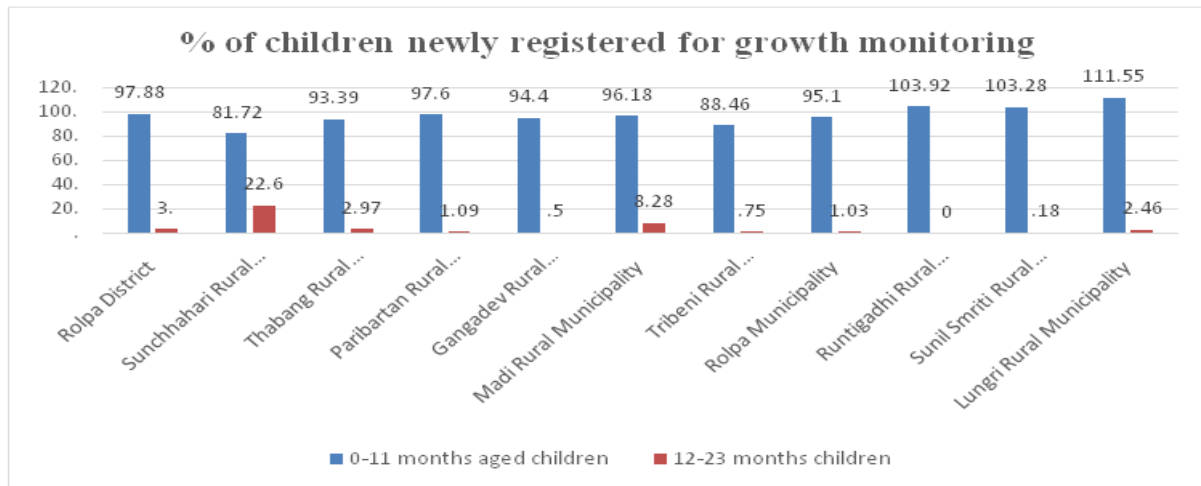
The percentage of women who received a 180-day supply of Iron Folic Acid during pregnancy was 76.6% in fiscal year 2081/82 in Rolpa district, with the highest in Lungri Rural Municipality (86.58%) and lowest in Gangadev Rural Municipality (58.89%).

**2.4.5.3 Palika-wise distribution of Iron Folic Acid consumed by post-partum women**



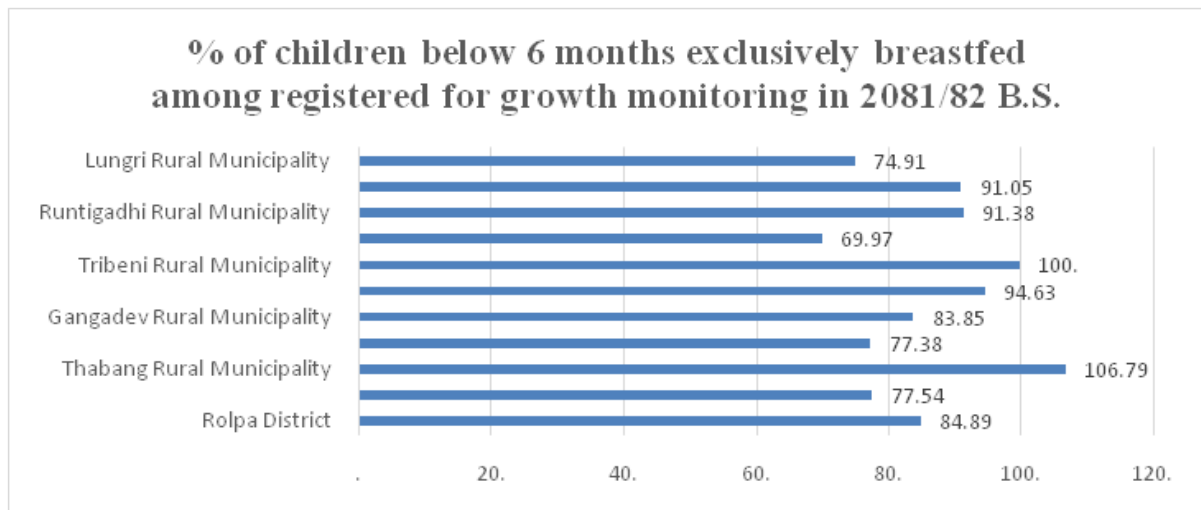
The percentage of postpartum women who received a 45-day supply of IFA was 100.6% in fiscal year 2081/82 in Rolpa district, with the highest in Sunchhahari Rural Municipality (22.6%) and lowest in Runtigadhi Rural Municipality (0%).

### 2.4.5.4 Palika-wise distribution of growth monitoring



The percentage of 0-11 months aged children newly registered and visited for Growth monitoring was 97.88% in fiscal year 2081/82 in Rolpa district, with the highest in Lungri Rural Municipality (111.55%) and lowest in Sunchhahari Rural Municipality (81.72%). Similarly, for 12-23-month-old children, the growth monitoring was 3% in fiscal year 2081/82 in Rolpa district, with the highest in Sunchhahari Rural Municipality (22.6%) and lowest in Runtigadhi Rural Municipality (0%).

### 2.4.5.5 Palika-wise distribution of exclusive breastfeeding



The percentage of children below six months exclusively breastfed among those registered for growth monitoring was 84.89% in fiscal year 2081/82 in Rolpa district, with the highest in Thabang Rural Municipality (106.79%) and lowest in Rolpa Municipality (69.97%).

### 2.4.5.6 Screening of under-five children by Health Workers

The screening of under-five children (6-59 months) by health workers using the Mid-upper arm circumference (MUAC) tape and their malnutrition status in FY 2081/82.

Name of LLG	Total number of screened children (N)	Result			Malnourished children,n(%)
		Normal,n(%)	Moderate, n(%)	Severe, n(%)	
SunchhahariRM	1036	1007 (97.20)	23(2.22)	6(0.58)	29 (2.80)
Thabang RM	641	630 (98.28)	10 (1.56)	1(0.16)	11 (1.72)
ParibartanRM	1301	1255 (96.46)	39 (3.00)	7(0.64)	46 (3.54)
Gangadev RM	1416	1361 (96.12)	50 (3.53)	5(0.35)	55 (3.88)
Madi RM	989	972 (98.28)	17(1.72)	0(0.00)	17 (1.72)
Tribeni RM	1218	1180 (96.88)	37 (3.04)	4(0.33)	42 (3.37)
Rolpa Municipality	1805	1774 (98.28)	30(1.66)	1(0.06)	31 (1.72)
RuntigadhiRM	1495	1393 (93.18)	37 (2.47)	9(0.60)	46(3.08)
Sunil Smriti RM	1946	1882 (96.71)	61 (3.13)	3(0.15)	64 (3.29)
LungriRM	1717	1663 (96.85)	39 (2.27)	9(0.52)	48 (2.80)
<b>Rolpa District</b>	13564	<b>13117(96.70)</b>	<b>343 (2.53)</b>	<b>45(0.33)</b>	<b>388 (2.86)</b>

Altogether, 13564 under-five children (6-59 months) were screened by health workers in Rolpa district in fiscal year 2081/82 B.S. Among them, 96.70% of the children were normal, 2.53% were moderately malnourished, and 0.33% were severely malnourished. The highest proportion of malnourished children was from Gangadev Rural Municipality (3.88%), and the lowest proportion of malnourished children was from Thabang Rural Municipality, Madi Rural Municipality, and Rolpa Municipality (1.72%).

### 2.4.5.7 Outpatient Therapeutic Centers (OTC)

OTC is for the treatment of malnutrition and offers services to severely malnourished children without any medical complications and having a normal appetite aged 6-59 months. These centers provide therapeutic feeding approaches such as therapeutic food distribution, and they cover 85-90% of SAM cases in the community and provide services through the local health facility.

Local Level Name	Health facility Name (OTC Center)	Number of MAM cases (6-59 months) admitted at the OTC center	Number of SAM cases (6-59 months) admitted at the OTC center	Total number of 6-59-month-old children admitted to the OTC center
Sunchhahari RM	Powang HP	0	3	3
Thabang RM	Thabang Basic Hospital	0	2	2
Paribartan RM	Kewari HP	0	7	7
Gangadev RM	Jinabang HP	0	2	2
Madi RM	Ghartigaun HP	10	2	12
Tribeni RM	Nerpa HP	0	0	0
Rolpa Mun	Liwang HP	0	4	4
Runtigadhi RM	Holeri PHC	18	0	18
Sunil Smriti RM	Sulichour PHC	0	4	4
Lungri RM	Badachour HP	0	2	2
<b>Rolpa District</b>		<b>28</b>	<b>26</b>	<b>54</b>

The total number of 6-59 months children admitted at the OTC center in Rolpa district in fiscal year 2081/82 B.S. is 54, out of which 28 of them were MAM cases and 26 of them were SAM cases. The highest number of 6-59 months old children admitted at the OTC center was from Runtigadhi Rural Municipality (18), and the lowest number was from Tribeni Rural Municipality (0).

### 2.4.6 Major activities in FY 2081/82

- Biannual Distribution of Vitamin A and Albendazole tablets under 5 years children
- Screening of the malnourished children under 5 years of all palikas
- Celebration of Breastfeeding Promotion Week, Nutrition Week, and Iodine Month, etc
- Regular growth monitoring of children under two years.
- School Health and Nutrition Programs
- Adolescent Girls' Iron Folic Acid Supplementation Program
- Regular supply and distribution of nutritional program commodities to HFs
- Supportive Supervision and Monitoring of nutrition-related activities in the district

- Identification of 1000 Days Households and monitoring the status accordingly
- Multi-Sectoral Nutritional Program conducted at the local level
- SHN week celebration throughout the district
- IEC/BCC intervention through local media and publications
- Treatment and management of malnourished children and support for improvements, and refer the severe malnourished cases to a nutritional rehabilitation home for further management
- Coordination with relevant stakeholders for cross-cutting issues regarding health and nutrition

#### 2.4.7 Issues, Recommendations and Responsibilities

Issues	Recommendation	Responsibilities
Poor recording and reporting of all nutritional indicators	Provide on-site coaching to improve the recording and reporting	MoH/HD/HO/LLG/HF
	ProvideHMIS training to newly recruited HWs.	
Fewer priorities on nutritional promotional activities at the local level of government	Programs and activities should be planned as stated in the multisectoral nutritional plan and link up with other governmental priorities.	LLG
Unavailability of a nutritional rehabilitation home in the district	One nutritional rehabilitation home in each district needs to be established	MoHP/DoHS/MoH
Poor linkages between the line agencies and stakeholders	Establish the linkages between concerned stakeholders like agriculture, livestock, and the education sector, etc., to quality improvement of nutritional status.	MoH/HD/HO
Inadequate nutrition-related equipment (Height and weight machine) in health facilities	Supply adequate height-weight machines to health facilities	MoH/HD/HO

## **2.5 Family Planning and Reproductive Health Program**

### **2.5.1 Introduction**

Family planning (FP) and reproductive health (RH) aim to improve the health and well-being of people and families by empowering them to make informed decisions regarding their reproductive health. In the early 1960s, Nepal implemented a comprehensive strategy for FP and community health that paved the path for safer childbirth and safer motherhood. It has been enshrined as a fundamental right in the Constitution of Nepal 2072 B.S and included in the basic health service package under the Public Health Service Act 2075. In addition, the Safe Motherhood and Reproductive Health Rights Act 2075, Safe Motherhood and Reproductive Health Rights Regulation 2077, 16th Five-Year Periodic Plan of Nepal (2081/82 - 2085/86 BS), as well as Safe Motherhood and Newborn Health Roadmap (2076-2087) emphasize the availability and accessibility of right-based FP services.

The strategic focus involves ensuring access and utilization of high-quality, client-centered FP services, particularly targeting underserved populations and achieving Sustainable Development Goals (SDGs) targets. Efforts are directed towards reducing contraceptive discontinuation, scaling up successful innovations, generating evidence, and linking FP services with RH services. FP information and services are disseminated through government sectors, social marketing, Non-Government Organizations (NGOs), the private sector, and academic institutions. Access to services in remote areas is facilitated through satellite clinics, visiting providers, and mobile camps. Sterilization services are available at static sites and through scheduled outreach services. Private and commercial outlets, including pharmacies, clinics, and hospitals, also contribute to the availability of comprehensive FP services.

Lumbini province is also committed to improving equitable and rights-based access to voluntary, quality FP services with special focus on hard-to-reach communities such as adolescents and youths, migrants, slum dwellers, ethnic minorities, sexual minorities, and other vulnerable groups, ensuring no one is left behind through its service outlets and by coordinating with local-level governments. Several policies and strategies in the province, such as the provincial health policy 2077, the second five-year periodic plan, and the province's commitment to the SDGs, create a favorable policy environment for family planning programs.

## 2.5.2 Objectives

### 2.5.2.1 General Objective

The overall objective of Nepal's FP program is to improve the health status of all people through informed choice on accessing and utilizing client-centered quality voluntary FP.

### 2.5.2.2 Specific Objective

The specific objectives are as follows:

1. To increase access to and the use of quality FP services that are safe, effective, and acceptable to individuals and couples.
2. A special focus is on increasing access in rural and remote places with a focus on marginalized people with high unmet need, postpartum and post-abortion women, and partners of labor migrants and adolescents.
3. To increase contraceptive use, reduce unmet need for FP, unintended pregnancies, and contraceptive discontinuation.
4. To create an enabling environment for increasing access to quality FP services to men and women, including adolescents.
5. To increase the demand for FP services by implementing strategic behavior change communication activities.

## 2.5.3 Policies and strategic areas

1. **Enabling environment:** Strengthen the enabling environment for FP.
2. **Demand generation:** Increase health care-seeking behavior among populations with high unmet need for modern contraception
3. **Service delivery:** Enhance FP service delivery, including commodities, to respond to the needs of marginalized people, rural people, migrants, adolescents, and other special groups
4. **Capacity building:** Strengthen the capacity of service providers to expand FP service delivery
5. **Research and innovation:** Strengthen the evidence base for program implementation through research and innovation

### 2.5.4 Status and targets

Indicators	National Status in 2022 (NDHS)	SDG 2030 target
1. Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods	74	80
2. Contraceptive prevalence rate (CPR) (modern methods) (%)	53	60
3. Total Fertility Rate (TFR) (births per woman aged 15-49 years)	2.1	2.1
4. Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group	51	30

### 2.5.5 Indicators of Family Planning and Reproductive Health Program

#### 2.5.5.1 Major Indicators of the FPRH program in Rolpa district

Indicators	Fiscal Years		
	2079/80	2080/81	2081/82
1. % Women of Reproductive Age (WRA) using modern contraceptive methods	34.7	36.5	44.96
2. Five FP methods service sites (condom, pills, depo, implant, and IUCD)	15.46	15.09	16.41
3. % of Post-partum mothers (PPM) using modern contraceptive methods	17.72	18.63	34.89

#### 2.5.5.2 Service outlets for the FPRH program in the Rolpa district

Indicators	Fiscal Years		
	2079/80	2080/81	2081/82
Proportion of health facilities providing Implant services	39.18	44.33	53.61
Proportion of health facilities providing IUCD	20.62	20.62	24.74
Number of VSC Sites (Mobile camp)	7	10	18

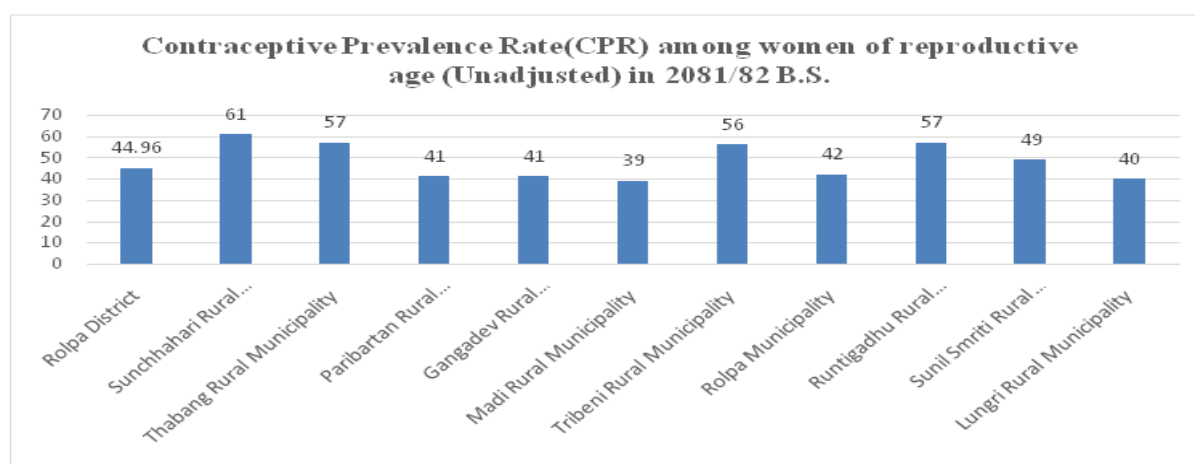
The proportion of health facilities providing Implant services is on an increasing trend since the last three fiscal years and was 53.61% in 2081/82 B.S. Similarly, the proportion of health facilities increased since the last fiscal year and was 24.74% in fiscal year 2081/82. The number of VSC sites (mobile camp) for permanent sterilization increased since the last three fiscal years and was 18 in 2081/82 B.S.

### 2.5.5.3 Distribution of voluntary surgical contraception cases in 2081/82 B.S.

LLG Name	Minilap	Vasectomy	Total
Sunchhahari Rural Municipality	3	11	14
Thabang Rural Municipality	9	6	15
Paribartan Rural Municipality	8	19	27
Gangadev Rural Municipality	10	11	21
Madi Rural Municipality	13	4	17
Tribeni Rural Municipality	7	11	18
Rolpa Municipality	21	13	34
Runtigadhi Rural Municipality	15	3	22
Sunilsmriti Rural Municipality	1	6	7
Lungri Rural Municipality	8	9	17
<b>Rolpa District</b>	<b>95</b>	<b>93</b>	<b>188</b>

There were a total of 188 Voluntary Surgical Contraception (VSC) cases in Rolpa district in fiscal year 2081/82 B.S., of which 95 cases were minilap and 93 cases were vasectomy. The highest number of VSC cases was from Rolpa municipality (34 cases), and the lowest number of VSC cases was from Sunilsmriti Rural Municipality (7 cases).

### 2.5.5.4 Palika-wise distribution of CPR



The CPR of Rolpa district in fiscal year 2081/82 B.S. was 44.96% with the highest and lowest CPR in Sunchhari Rural Municipality (61%) and Madi Rural Municipality (39%).

### 2.5.5 Major activities under the FPRH program in the Rolpa district

The major activities carried out by the Rolpa district under the FPRH program in FY 2081/82 B.S. are:

- Provision of regular comprehensive FP service, including post-partum and post abortion FP services
- Provision of long-acting reversible services (LARCs)
- Introduction and availability of emergency contraceptive pills (ECP) services through all public health facilities and FCHVs
- Pre-VSC Interaction program of health service providers, FCHVs, and local stakeholders
- The VSC camp was conducted in 10 municipalities.
- Interaction program on FP in marginalized communities
- Monitoring and Supervision of FP and RH programs
- FP microplanning program for underserved and hard-to-reach areas

### 2.5.6 Issues, Recommendations, and Responsibilities

<b>Issues /Challenges</b>	<b>Recommendations</b>	<b>Responsibilities</b>
Inadequate number of Implant and IUCD service sites	Expansion of Implant and IUCD service sites by providing training	HO, HTC, LLG
Report Collection from private clinics not included in HMIS	Establish a system to collect reports from private clinics regularly	HF, LLG, MoH
Low FP acceptors among post-abortion and post-partum women	Strengthen post abortion and post-partum FP counseling	LLG, HF
VSC service is limited to the mobile camp only	Provide regular VSC service through the district-level Institution	HO, MOH, HTC
Seasonal demand of FP during the festival (as the periodic out-migrants return to their home during the festival time)	Prepare FCHVs to address the seasonal demand of FP.	LLG, HF

## 2.6 Adolescent and Reproductive Health

### 2.6.1 Introduction

In Nepal, addressing the special needs of adolescents through Adolescent Sexual and Reproductive Health (ASRH) is a vital part of the nation's public health agenda. Since 23.6% of the population is between the ages of 10 and 19 as per the National Population and Housing Census (NPHC) 2021, which indicates that about one-fourth of Nepal's population falls into the adolescent age group, Nepal places a high priority on ASRH through extensive initiatives that emphasize empowerment, education, and services. These programs support gender equality and rights, encourage access to adolescent-friendly health care, and offer age-appropriate information on sexual and reproductive health. Menstrual health management, STI and HIV prevention, teenage pregnancy and early marriage prevention, and mental health assistance are important elements. Among adolescent girls aged 15-19 in Nepal, 17% are either mothers or currently pregnant, while only 14.2% of married adolescents use modern contraceptives.

Nepal, a pioneer in South Asia, endorsed its first National Adolescent Health and Development (NAHD) Strategy in 2000, later revised in 2018 to address evolving adolescent issues. GoN has a national strategy for adolescent health and a strategy to enable and prioritize adolescent health issues, including sexual and reproductive health. The Adolescent Friendly Health Facility (AFHF) Implementation Guideline 2079 B.S. was developed and endorsed by the Government of Nepal to enhance the accessibility and quality of health services tailored specifically for adolescents.

### 2.6.2 Vision, Mission, Goal, Objectives, Strategic Principles, and Directions

As per the National Adolescent Health and Development (NADH) Strategy, 2018, vision, mission, goal, objectives, strategic principles, and directions are as follows.

**Vision:** To enable all adolescents to be healthy, happy, competent, and responsible.

**Mission:** Optimum use of the available methods and establishing a strong bond between the

concerned parties, and developing a strategy with the view of securing the health and development of adolescents.

**Goal:** To promote the sexual and reproductive health of adolescents

**General Objectives:** By the year 2025, all adolescents will have positive lifestyles to enable them to lead healthy and productive lives.

### Specific Objectives

- To increase the availability of and access to quality information on adolescent health and development, and provide opportunities to build the knowledge and skills of adolescents, service providers, and educators
- To increase the accessibility and use of adolescent health and counseling services.
- To create safe and supportive environments for adolescents to improve their legal, social, and economic status
- To create awareness on adolescent issues through BCC campaigns and at national, provincial, and community levels through FCHVs and mother groups.

### Strategic Principles and Direction

The National Adolescent Health and Development Strategy (2018) takes into account the social determinants that influence social conditions where the health sector will lead and support the process of building multi-sectoral collaboration through government, non-governmental, and private partnerships. As per the strategy, the formulation of plans, program implementation, and monitoring at all levels and stages are based on the following key principles.

**a. Participation and Leadership of Adolescents:** The strategy encourages conditions that create opportunities for adolescents. It also facilitates the active participation and leadership of adolescents at all levels of decision-making, planning, implementation, and evaluation related to programs. Existing community and local level structures, such as health institution management committees or structures established for health institution management, school management committees, and structures developed by other concerned ministries, will ensure the regular membership of adolescents in these committees. Similarly, the participation of adolescents in decision-making processes will be ensured in community organizations, clubs, and other local structures related to adolescents.

**b. Equality and equity:** The strategy will encourage the formulation of programs by focusing on the equitable and inclusive inclusion of adolescents in all programs. Special attention will be given to addressing the health needs of marginalized groups based on economic status, geographical conditions, and other social diversities and characteristics. The strategy will also address the health needs of adolescents with different disabilities, sexual minorities, Lesbian, Gay, Bisexual, Transgender, Intersex, Queer (LGBTIQ), and special subgroup adolescents. Additionally, marginalized, backward groups and the needs of adolescence will be prioritized.

**c. Right with responsibility:** When designing programs for adolescents, their right to receive quality health services and respect for their confidentiality will be ensured. Mechanisms will be established to ensure that their voices are included at all stages of the program cycle. Adolescent health programs will identify and address the special gender needs of adolescents in an equitable and non-discriminatory manner. The strategy ensures gender equality in program planning and also makes adolescents responsible for it.

**d. Strategies partnership:** The National Adolescent Health and Development Strategy (2018) will also embrace the essence of the National Action Plan (2013/14 - 2017/18) for the overall development of adolescents. It will develop strategic partnerships at all levels for the formulation and implementation of adolescent-related programs involving other concerned ministries of the federal government, provincial and local governments, external and internal development partners, other federal institutions, and the private sector. Programs related to adolescent health and development will be translated as interrelated subjects, with the health sector taking a leading and responsible role in this.

**e. Expansion of Adolescent Programs through Partnership among Government, Non-Governmental, and Private Sectors:** Adolescent programs will be expanded through the involvement and partnership of government, non-governmental, and private sectors at the federal, provincial, and local levels. For this purpose, programs will be designed for adolescents through organizations of the private sector, such as education, health, industry, commerce, and business associations, creating opportunities for the development of their multidimensional personalities and capacities.

**f. Role of federal, provincial, and local government:** The provincial government will formulate a provincial adolescent health and development strategy based on an analysis of its economic, geographical, social, and educational conditions, available services, facilities, and opportunities, as well as the cultural, religious, linguistic, and lifestyle aspects of adolescents. New technologies and opportunities will be created for the overall development of adolescents. Programs of interest will be selected and implemented according to the policies and guidelines of the federal and provincial governments.

**Federal Level:** Adolescents-focused health and development activities can be supported and implementation ensured in the following ways.

1. Ensuring that adolescent health and development issues are included in all policies, strategies, guidelines, and plans.
2. Promoting effective coordination, collaboration, and multilateral efforts through increased debates/advocacy.
3. Securing adequate planning and budget support.

**Provincial Level:** Based on the policies and strategies prepared by the federal government, the provincial level can support and ensure the implementation status of adolescent-focused health and development activities in the following ways.

1. Ensuring the inclusion of adolescent health and development-related issues in all provincial policies.
2. Empowering health workers and health institutions.
3. Developing participatory monitoring and positive inspection systems.
4. Regulating/operating planning and budget support from various stakeholders (both governmental and non-governmental organizations).
5. Establishing coordination among local, provincial, and federal levels, as well as relevant stakeholders and partners.
6. By ensuring the participation of adolescents in community-level structures such as the Health Institution Operation and Management Committee and the School Management Committee.

**Local level (village/municipality level):** Local governments can allocate budgets and programs for adolescent health and development as follows.

1. Ensuring that the needs of adolescents are addressed when planning, budgeting, and creating programs at the local level.
2. Ensuring the participation of adolescents in capacity-building activities.
3. Assisting in participatory monitoring and evaluation for necessary coordination during program implementation.
4. Establishing separate mechanisms to address the needs of adolescents with special requirements.
5. Discussing/advocating for adolescent-related issues and management, and mobilizing support.
6. Ensuring the invited or mandatory presence of adolescents in community-level structures such as the Health Institution Operation and Management Committee and the School Management Committee.

### **2.6.3 Key Intervention Areas for ASRH Program**

1. School health nurse program
2. ASRH site certification
3. Capacity building of health workers
4. Scale up and strengthen health facilities for Adolescent Friendly Services (AFS)
5. Establishment of Adolescent Friendly Information Corners (AFICs) in schools.
6. ASRH training for health workers
7. Menstrual Hygiene Management (MHM)
8. Comprehensive Sexuality Education (CSE) in School
9. Advocacy

## 2.6.4 Key Indicators of ASRH Program

### 2.6.4.1 Major indicators of the ASRH Program in Rolpa district

Indicators	Fiscal Years		
	2079/80	2080/81	2081/82
Total number of adolescent girls who received ANC service within 12 weeks (under 20 years)	713	696	601
Total number of adolescent girls who received 4 ANC services (under 20 years)	531	553	460
Total number of adolescent girls who received 8 ANC services (under 20 years)	196	415	355
Percentage of deliveries below 20 years of age among total institutional deliveries	18.3	19.4	15.8
Total number of adolescent girls' safe abortion cases (Medical + Surgical) (under 20 years)	80	52	0
Depo User (under 20 years)	433	289	274
Pills User (under 20 years)	124	111	78
Implant User (under 20 years)	36	50	42
IUCD User (under 20 years)	1	0	2

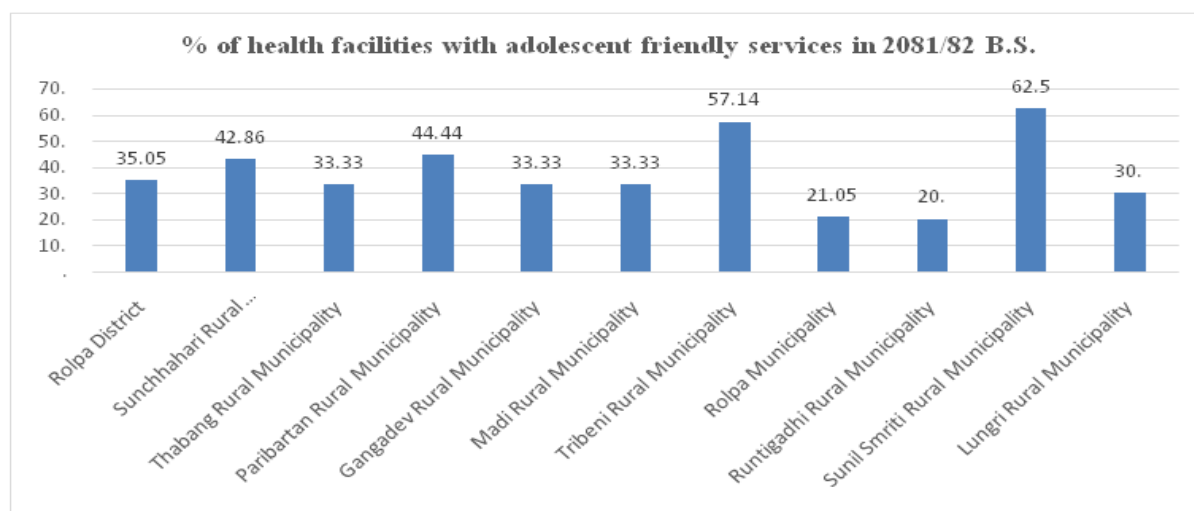
The total number of adolescent girls who received eight ANC visits as per protocol was 355 in Rolpa district in fiscal year 2081/82, which was less than the last fiscal year. Similarly, the percentage of institutional deliveries in adolescents has been in a decreasing trend since the last three fiscal years. The total number of adolescent girls' safe abortion cases was zero in fiscal year 2081/82.

### 2.6.4.2 ASRH-certified health facilities in Rolpa district

The criteria of adolescent-friendly services (AFS) include the availability of trained staff and information on adolescent sexual and reproductive health, the delivery of services in a confidential way, adolescent-friendly opening hours, the display of the AFS logo, and including two adolescents as invitees to HFOMC meetings.

Name of LLG	No of AFS Certified HF
Sunchhahari Rural Municipality	3
Thabang Rural Municipality	3
Paribartan Rural Municipality	4
Gangadev Rural Municipality	3
Madi Rural Municipality	3
Tribeni Rural Municipality	4
Rolpa Municipality	4
Runtigadhi Rural Municipality	2
Sunil Smriti Rural Municipality	5
Lungri Rural Municipality	3
<b>Total (in Rolpa District)</b>	<b>34</b>

Initially, the Rolpa district identified 13 Health Facilities for the ASRH program in FY 2069/70. Now, altogether 34 health facilities in the district were listed as AFS sites for the provision of quality Adolescent Friendly Health Services. Furthermore, to ensure quality and sustainability of the ASRH program, the remaining HF's are going through the process of listing as an AFS site and a means of certification.



The proportion of health facilities with adolescent-friendly services in 2081/82 was 35.05 in Rolpa district, with the highest proportion in Sunil Smriti Rural Municipality (62.5%) and the lowest proportion in Runtigadhi Rural Municipality (20%).

### 2.6.4.3 School Health Nurse (SHN) Program in the Rolpa district

The main goal of the School Health Nurse Program is to develop the physical, mental, emotional, and educational status of the school children. This goal is supported by four strategic objectives.

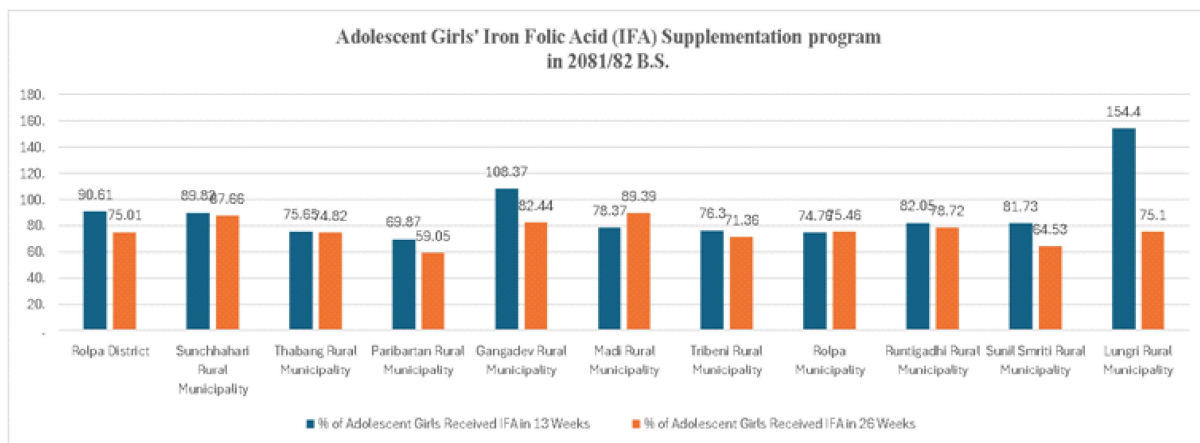
- Improve the use of School Health and Nutrition services
- Improve a healthy school environment
- Improve health and nutrition behaviors and habits
- Improve and strengthen the community support system and policy environment.

Altogether, there are 18 School Health Nurses (11 School Health Nurses are currently working as federal employees and 7 as provincial employees) in different schools of the Rolpa district.

### 2.6.4.4 Palika-wise distribution of Adolescent Girls' Iron Folic Acid (IFA) Supplementation program

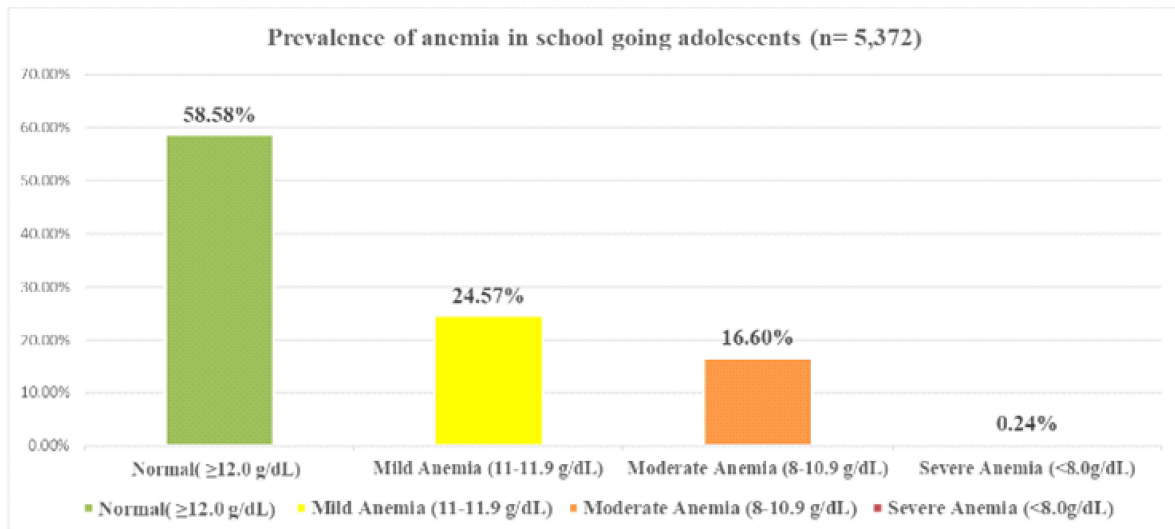
SHN Program has initiated weekly Iron Folic Acid (IFA) supplementation to the adolescent girls aged 10-19 years from FY 2072/73, aiming to prevent and control the high burden of Iron Deficiency Anemia (IDA) among this particular group of population. This activity was piloted in Kathmandu, Dolakha, Khotang, Panchthar, Bhojpur, Saptari, Pyuthan, and Kapilvastu districts in FY 2072/73. Now the program is scaling up to 77 districts of Nepal.

Under this component, almost all the adolescent girls aged 10-19 years are supplemented with weekly Iron Folic Acid biannually in Shrawan (Shrawan -Asoj) and Magh (Magh- Chaitra) rounds. In each round, they are provided with one IFA tablet every week for 13 weeks. So, each adolescent girl gets a total of 26 IFA tablets in a year.



The above bar diagram shows that the overall IFA distribution status of the district has been decreasing over 26 weeks than 13 weeks, where 90.61% in 13 weeks and 75.01% in 26 weeks.

### 2.6.4.5 Anemia Status Assessment (Hameglobin test) Program in Adolescent Girls



The prevalence of anemia in school-going adolescents was 41.42% of which 24.57% were mildly anemic, 16.60% were moderately anemic, and 0.24% were severely anemic in Rolpa district in 2081/82 B.S. under “Blood Sample Testing Program for Adolescents of Community Schools 2081/82” of the provincial government.

### 2.6.5 Major Activities of the ASRH Program in Rolpa District

- Iron Folic Acid supplementation for adolescent girls
- Performed anemia status assessment (hemoglobin test) among 55 community schools, representing two schools from each LLG
- Whole site orientation regarding the Adolescent Program Implementation Guideline to the HF team
- Distributed ASRH flip chart, adolescent job aids to AFS health facilities
- AFS site verification, pre-certification, and certification program.
- School health orientation program to school teachers and the Health facility in charge.
- Program orientation to local stakeholders, including HFOMC members, FCHVs in program HFs
- Community awareness activities through existing structures
- School health program by the school health nurse
- Monitoring and supportive supervision of the ASRH program

**2.6.6 Issues, Recommendations, and Responsibilities of the ASRH Program in Rolpa District**

<b>Issues/Challenges</b>	<b>Recommendations</b>	<b>Responsibilities</b>
High prevalence of early marriage and teenage pregnancy	Intensify community awareness activities and effectively implement the law	MoH, policymakers, LLG, and HO
Timing is not friendly for students to come to the health facility for AFHS.	Specify the day and time for service to adolescents	HF, HFOMC, School, R/M
Lack of adequate space and facilities as per the ASRH guideline in most of the health facilities	More support for infrastructure to make HF adolescent-friendly	FWD, HO, LLG, EDPs
Lack of adequately trained health staff for adolescent and youth counseling	Provision of counseling training to HFs, preferably from both male and female genders	FWD, MoH, HO, EDPs
Lack of community awareness and the importance of adolescent sexual and reproductive health	-Needed to expand the ASRH program to the community level -Orientation is needed for the guardian	HO, HF, EDPs
The Newly Constructed HF Building has no Space for the AFS Corner.	Design of the AFS room in the newly constructed health facility building	MD/DUDBC/LLG
Poor coverage/ performance of the IFA distribution program for adolescent girls	The program needs to link with the School Health and Nutrition program and implement jointly with the focal teacher and health workers, with certain incentives.	MoSD/MOH/HD/HO/LLG

## 2.7 Primary Health Care Outreach Clinic Program

### 2.7.1 Introduction

In Nepal, the Primary Health Care Outreach Clinic (PHC/ORC) program was established in 2051 (1994) as a community-based effort to improve underprivileged and isolated populations' access to basic healthcare services. Family planning, immunization, maternity and postnatal care, treatment of common illnesses, and health education are just a few of the preventive, promotional, and curative services offered by PHC/ ORCs, which function as extensions of primary healthcare facilities and health posts. These clinics are held monthly at set places, times, and dates to ensure that their target populations can get to them within a half-hour walk. ANMs, paramedics, FCHVs, and local NGOs collaborate to provide basic primary health care services based on local needs.

### 2.7.2 Health services under PHC/ORC

According to the PHC/ORC strategy, the following services are provided from the clinic.

<p><b>a. Safe Motherhood &amp; Newborn Care</b></p> <ul style="list-style-type: none"><li>• Antenatal, postnatal, and newborn care</li><li>• Iron distribution</li><li>• Referral if danger signs are identified</li></ul> <p><b>b. Child Health</b></p> <ul style="list-style-type: none"><li>• Growth monitoring of children under 2 years</li><li>• Pneumonia/Diarrhea treatment</li></ul> <p><b>c. Family Planning</b></p> <ul style="list-style-type: none"><li>• DMPA (Depo-Provera), pills, and condoms</li><li>• Monitoring of continuous users</li><li>• Education and counseling on FP methods and emergency contraception</li><li>• Counseling and referral for IUCD, implant, and VSC service</li><li>• Tracing defaulter</li></ul>	<p><b>d. Health Education and Counseling</b></p> <ul style="list-style-type: none"><li>• Family planning</li><li>• Maternal and newborn care</li><li>• Child health</li><li>• STI, HIV/AIDS</li><li>• Adolescents' sexual and reproductive health</li></ul> <p><b>e. First aid treatment</b></p> <ul style="list-style-type: none"><li>• Minor treatment and referral for complicated cases</li></ul>
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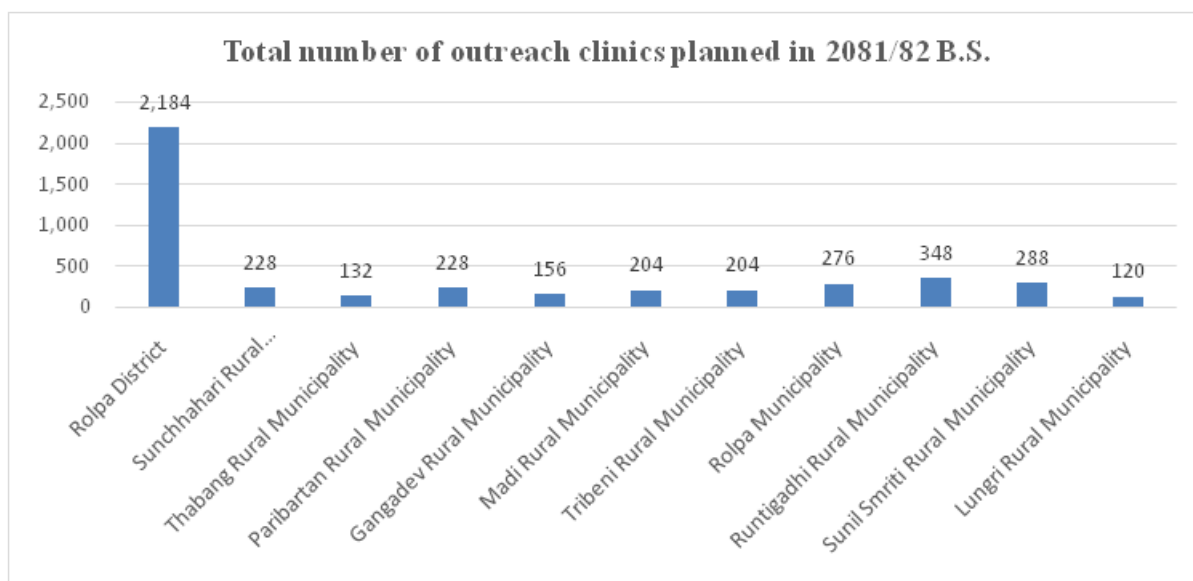
### 2.7.3 Key indicators of PHC/ORC program

#### 2.7.3.1 Three-year trend of major Indicators of the PHC/ORC Program in Rolpa District

Indicators	Fiscal Years		
	2079/80	2080/81	2081/82
Total number of outreach clinics planned	2068	2136	2184
PHC/ORC conducted (%)	97.29	98.08	99.95
Average number of people served per clinic	21.8	23.8	22.13

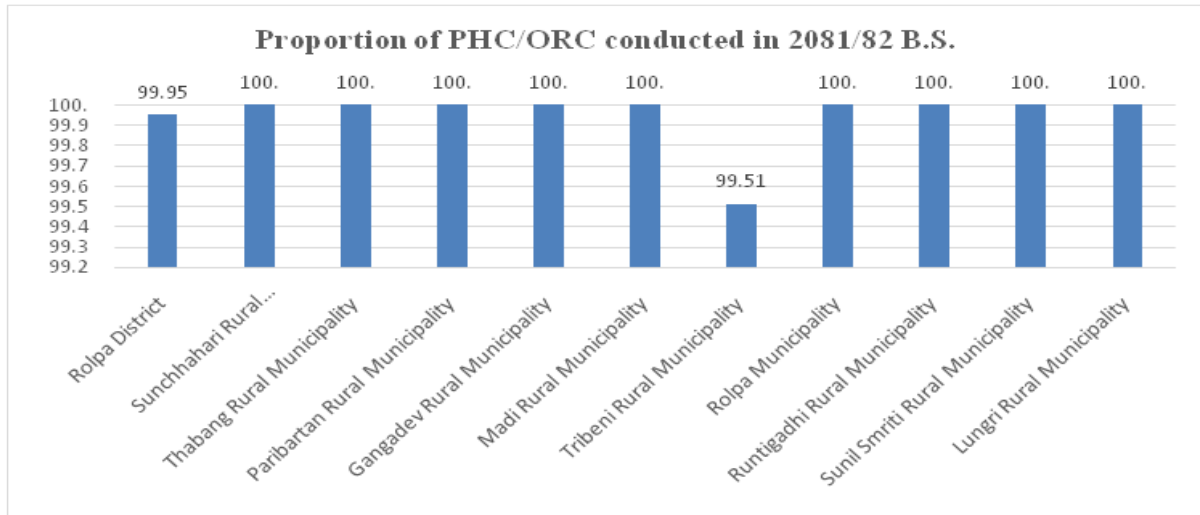
The total number of outreach clinics planned was in an increasing trend and was 2184 in fiscal year 2081/82. Similarly, the PHC/ORC session conducted percentage also increasing trend (97.29 to 99.95%), which is good. The average number of people served per clinic was 22.13 in fiscal year 2081/82, which is less than the last fiscal year.

#### 2.7.3.2 Palika-wise distribution of PHC/ORC planned in Rolpa District



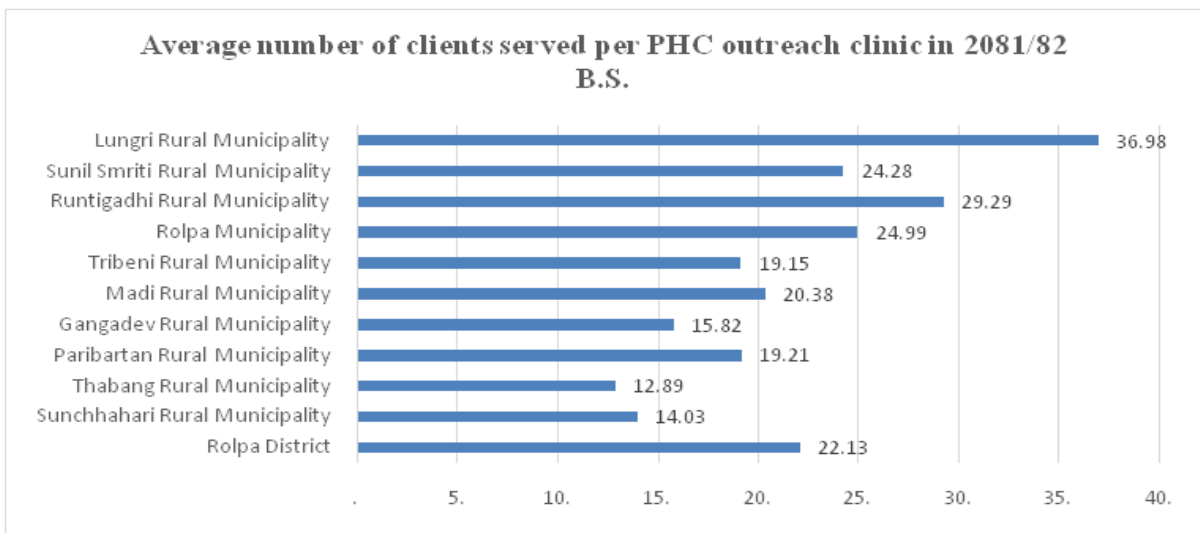
The total number of outreach clinics planned was 2184 in Rolpa district in fiscal year 2081/82 B.S, with the highest number of outreach clinics planned in Runtigadhi Rural Municipality (348) and the lowest number of outreach clinics planned in Lungri Rural Municipality (120).

**2.7.3.3 Palika-wise distribution of proportion of PHC/ORC conducted in Rolpa District**



The proportion of PHC/ORC conducted was 99.95% in Rolpa district in fiscal year 2081/82 B.S, with 100% in all LLGs except in Tribeni Rural Municipality (99.51%).

**2.7.3.4 Palika-wise distribution of the average number of people served per PHC/ORC in Rolpa District**



The average number of people served per PHC/ORC was 22.13 in Rolpa district in fiscal year 2081/82 B.S, with the highest number in Lungri Rural Municipality (36.98) and the lowest number in Thabang Rural Municipality (12.89).

**2.7.4 Major Activities in FY 2081/82**

- Ensuring proper delivery of preventive, promotive, and curative health services through different health institutions in the district.
- Managing supplies of drugs, equipment, and materials to health facilities.
- Identifying gaps in health service delivery and seeking solutions.
- Conducting supervision and monitoring of health services at outreach clinics.

**2.7.5 Issues/Challenges, Recommendations, and Responsibilities:**

Issues/Challenges	Recommendations	Responsibilities
Congested room/corner for PHC ORC	Strengthen the PHC/ORC committee for local resource mobilization for the construction of a room for PHC/ORC.	HO, HF, HFOMC, HMG, R/M
Some PHC/ORC are not properly conducted as per the guidelines	Provide regular orientation and refresher training to PHC/ORC staff on national guidelines, and strengthen supervision and monitoring by local health authorities.	HFOMC, HF, R/M
Inadequate human resource mobilization to conduct the clinics	Mobilize AHWs and ANMs to every clinic.	HO, HF, HFOMC, R/M
Lack of field allowance for additional staff mobilization	Endorse a policy to provide allowance for field staff	FWD, DoHS, R/M

# EPIDEMIOLOGY AND DISEASE CONTROL PROGRAM

## 3.1 Tuberculosis

### 3.1.1 Introduction

Tuberculosis (TB) is a significant public health issue in Nepal and one of the leading causes of global mortality. It is caused by *Mycobacterium tuberculosis* and primarily affects the lungs, but can also manifest in other body parts. Nearly a quarter of the global population carries the TB bacteria. This disease is closely linked to poverty and disproportionately impacts adults, particularly men. Despite being curable and preventable, access to diagnosis and care falls short of UHC, affecting a substantial portion of the population in Nepal. Annually, the program assesses the TB epidemic status and tracks progress in response efforts. It gathers data from multiple sources, including the National Tuberculosis Control Center (NTCC), the Health Management Information System (HMIS), the National Tuberculosis Program Management Information System (NTPMIS), and WHO country profiles.

### 3.1.2 TB Burden Estimate

Globally, an estimated 10.8 million people fell ill with TB in 2023. The disease resulted in 1.25 million deaths, while 4,00,000 people developed multi-drug resistant/ rifampicin-resistant (MDR/RR) TB. In the same year, in the South-East Asia Region (SEAR), 2.5 million people were diagnosed with TB, 1,29,000 deaths occurred, and 60,000 people with MDR/RR-TB were estimated. According to the National TB Prevalence Survey Report (2076/2020), Nepal's annual TB prevalence is 1,17,000, the incidence is 69,000, and TB-related deaths are 17,000. These figures are 1.8 times, 1.6 times, and 3.1 times higher than the previous estimates, respectively. Although the incidence is higher than the previous estimates, the incidence rate is declining by 3% annually. An assumed 3% rate of decline in incidence over the period 2057-2075 (2000-2018) was used, supported by a steep gradient in prevalence rates over groups of increasing age, suggesting a decline in transmission, and an average 8% per year growth in Gross National Income (GNI)/capita.

In 2079 (2023), Nepal faced a TB burden of an estimated 68,000 cases, with an incidence rate of 229 per 100,000 population. HIV-related TB cases totaled 430, with an incidence rate of 1.4 per 100,000 population, while 3,000 individuals were affected by Multi-Drug-Resistant/Rifampicin-Resistant (MDR/RR) TB, at a rate of 10 per 100,000 population. The mortality impact was significant, with 16,000 HIV-negative TB deaths (mortality rate: 54 per 100,000) and 200 HIV positive TB deaths (mortality rate: 0.69 per 100,000).

The proportion of MDR/RR-TB cases is 4% among new cases and 8.8% among previously treated cases. These statistics highlight the significant challenges and intensified efforts needed to effectively address TB in Nepal.

### 3.1.3 Vision, Goal, Objectives, and strategies for the TB program

Based on the National Strategic Plan 2079/80- 2083/84 (2021/22-2025/26) for TB, the vision, goal, objectives, and strategies for the National TB program are as follows.

**Vision:** A world free of Tuberculosis by 2050. Zero deaths, disease, and suffering due to tuberculosis.

**Goal:** Nepal has set a goal to decrease the incidence rate from 238 in 2020/21 to 181 per 100,000 population by 2025/26; decrease mortality rates from 58 in 2020/21 to 23 per 100,000 by 2025/26; end the TB epidemic by 2035; eliminate TB by 2050; and reduce the catastrophic cost to zero.

#### Objectives:

1. To build and strengthen political commitment, sustainability, and a patient-friendly health system to end TB.
2. To ensure the identification of TB, diagnosis, quality treatment, and prevention.

#### Strategies:

1. Improve the quality of TB services and strengthen the health system for universal access to TB services; enhance the TB services and support by increasing community engagement in TB management, and strengthen the digitalized case-based surveillance system in health care facilities.
2. Strengthen laboratory services to further improve the management of TB diagnosis and treatment.
3. Quality Improvement of the services for TB prevention, identification, and treatment.

### 3.1.4 Status and targets for the TB program

Indicators	Milestone	Target SDG 2030	END TB 2035
1. Reduction in the number of TB deaths compared with 2015 (%)	35	90	95
2. Reduction in TB incidence rate compared with 2015 (%)	20 (<85 per 1,00,000)	80 (<20 per 1,00,000)	90 (<10 per 1,00,000)
3. TB-affected families facing catastrophic costs due to TB (%)	Zero	Zero	Zero

### 3.1.5 Major indicators of the TB program

#### 3.1.5.1 Major indicators of the TB program in the Rolpa district

Indicators	Fiscal Years		
	2079/80	2080/81	2081/82
Case Notification Rate (New PBC and Relapse)	118	134	107
Case Notification Rate (All forms of TB)	120	135	108
Treatment Success Rate of TB	94	93	93
Deaths due to TB	3	3	4

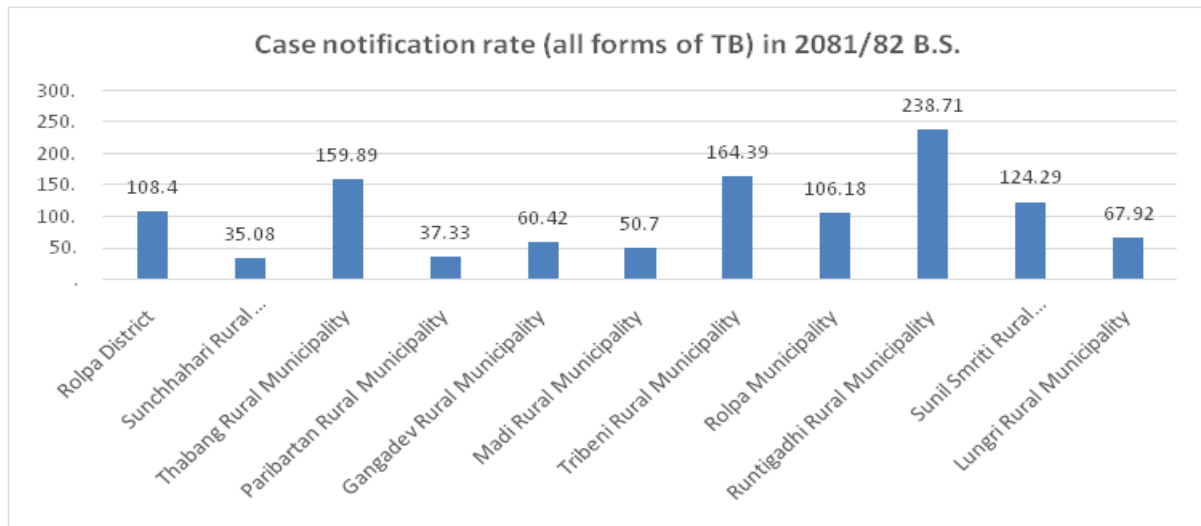
The Case Notification Rate of all forms of TB was less than the last fiscal year and was 107% in fiscal year 2081/82 B.S. in Rolpa district. Similarly, the treatment success rate was 93% and there were four deaths due to TB in fiscal year 2081/82 in Rolpa district.

#### 3.1.5.2 TB Microscopy Centers in Rolpa district

S.N.	Local Level Name	Name of TB Microscopy Center	No of Sites
1	Sunchhahari RM	Planning for Pobang HP	0
2	Thabang RM	Thabang HP	1
3	Paribartan RM	Rangsi HP	1
4	Gangadev RM	Planning for Jinabang HP	0
5	Madi RM	Ghartigaun HP	1
6	Tribeni RM	Nerpa HP	1
7	RolpaMun	Rolpa Hospital	1
8	Runtigadhi RM	Holeri PHC / Mashina HP	2
9	Sunil Smriti RM	Sulichour PHC / Ghodagaun HP	2
10	Lungri RM	Wadachour HP	1
<b>Total</b>			<b>10</b>

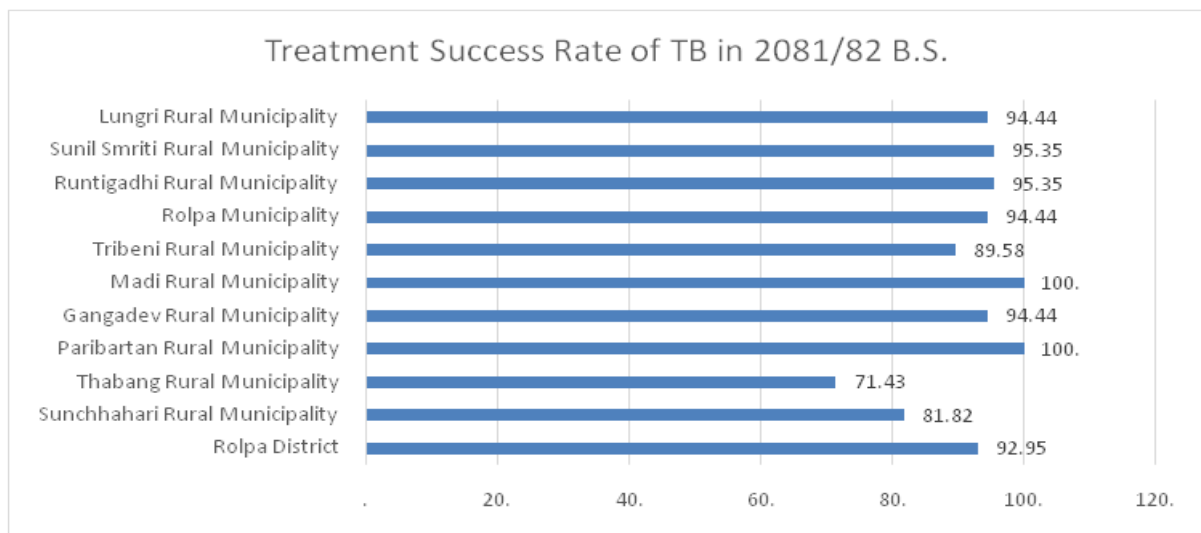
*There were a total of 10 microscopic centers in the Rolpa district in fiscal year 2081/82 B.S.*

### 3.1.5.3 TB notification rate in Rolpa district



The case notification rate of all forms of TB was 108.4 in Rolpa district in fiscal year 2081/82 B.S, with the highest case notification rate in Runtigadhi Rural Municipality (238.71) and the lowest case notification rate in Sunchhahari Rural Municipality (35.08).

### 3.1.5.4 TB treatment success rate in Rolpa district



The treatment success rate of TB was 92.95% in Rolpa district in fiscal year 2081/82 B.S, with a 100% treatment success rate in Madi and Tribeni Rural Municipality, and the lowest treatment success rate in Thabang Rural Municipality (71.43).

### **3.1.6 Major activities in the TB program in FY 2081/82**

- World TB Day was celebrated for an entire week in Rolpa, which contributed 2 cases to the district case notification through active case finding.
- Conducted District level Malaria, TB, and HIV multi-sector orientation and Prepared micro planning for further improvements.
- Conducted TB orientation, review, and micro planning event at all Local Level
- Conducted Annual and semiannual review/cohort analysis meeting
- Conducted TB ACF in Madi, Oat HP, Ghapa BHSC, Jankot HP, and Homa HP, and no cases were found.
- Conducted TB microscopic training to Kotgaun HP.
- Linkage of DOTS centers to Microscopic centers through courier
- Contact tracing of index TB cases
- Tuberculosis Preventive Therapy (TBPT) Intervention
- Childhood TB management at health facilities and hospitals
- Regular supply of medicine and commodities, including laboratory supplies
- IEC/BCC messages production and broadcasting via local media
- On-site coaching, Supportive Supervision, and monitoring to improve the TB program

### 3.1.7 Issues, Recommendations, and Responsibilities

Issues/Challenges	Recommendations	Responsibilities
Still, two local levels have not established a TB microscopy center.	Establish MC and ensure all the necessary resources.	RM, HO, PPHL, NTC
Low screening of presumptive TB cases from the OPD	Regular sputum testing of the presumptive cases by HFs	HFs, HO, R/M, EDPs
	Increment in the sputum courier system for transporting sputum from hard-to-reach areas.	
	Regularly conducting contact tracing as per protocol for all HF.	
TB-related HMIS registers are not recorded properly	The HMIS register should be recorded properly.	HFs, HO, R/M
	RDQA should be conducted regularly.	
The CB-DOTS program is not properly implemented.	Conduct the CB/DOTS program as per the implementing guideline.	R/M, HF
Insufficient income generation program for needy TB patients and drug-resistant TB patients, and their families	Explore sustainable methods to financially support the patients and their families.	HO, NTC, EDPs
The budget is not available for active case detection.	Ensure the financial budget for the Active case finding in the highly suspected and high-risk group population.	PHD/NTCC/MOHP

## **3.2. Leprosy Elimination Program**

### **3.2.1 Introduction**

The establishment of the Khokana Leprosarium in the nineteenth century was the beginning of organized leprosy preventive services in Nepal. In 1960, the then His Majesty's Government (HMG) of Nepal, in collaboration with the World Health Organization (WHO), conducted a leprosy survey with an estimated number of 100,000 leprosy cases. Later, Dapsone monotherapy was started as a pilot project in 1966 in Nepal. This project gradually expanded as a vertical program and remained so till 1987, when it was integrated into general health services. Multi-Drug Therapy (MDT) was introduced for the first time in Nepal in the year 1982/83 in a few selected areas and hospitals. By that time, the number of registered cases had come down to 31,537 (PR of 21 per 10,000). The number of districts then with a prevalence rate (PR) of over 5 was 62, and in only three districts the PR was less than 1 per 10,000. There was a gradual and steady expansion of MDT services, and by 1996, MDT coverage was extended to all districts of the country. Being a member country, Nepal is committed to the elimination of leprosy in line with the global program and is an active member of the global alliance for the elimination of leprosy as a public health problem. A six-year plan was developed in 1995 for strengthening the program. Accordingly, as per that plan, an estimation of leprosy prevalence was done, and all basic health staff (BHS) were provided training in Leprosy. Health Education was intensified to improve community awareness and to facilitate case detection. The first independent evaluation of the National Leprosy Control Program was undertaken during January (7th to 26th) 1996, by a group of experts representing the then HMG, WHO, and Non-governmental Organizations (NGOs). Two rounds of Leprosy Elimination Campaigns were organized in the years 1999 and 2000.

Following the continuous efforts from the Government of Nepal, Ministry of Health & Population, Leprosy Control Programme, WHO-Nepal, district health/public health office and concerned agencies, leprosy was eliminated as a public health problem at the national level in 2009 and declared in January 19, 2010 (2066 Magh 5) with a national registered prevalence rate of 0.77 cases per 10,000 population, which was below the cut-off point of below 1 per 10,000 population definition set by WHO.

The National Leprosy Elimination Program of Nepal is guided by the National Roadmap for Zero Leprosy (2021-30 AD) and the National Leprosy Strategy (2021-25 AD).

### 3.2.2 Vision, Goal, Objectives, and Strategic Pillars

**Vision:** Leprosy-free Nepal

**Goal:** Elimination of leprosy (Interruption of transmission of leprosy) at the subnational level (municipality) (Interruption of transmission is defined as zero new autochthonous child leprosy cases for consecutive five years at the municipality level).

**Objectives:**

1. To eliminate leprosy transmission at the subnational level (province, district, local level).
2. To strengthen clinical case management at the district and municipal levels and improve the referral system.
3. To enhance capacity building through training of health staff, particularly at the peripheral health facilities.
4. To enhance the prevention of leprosy.
5. Reduction of stigma and discrimination.
6. To strengthen the leprosy surveillance system and regular monitoring, supervision, and periodic evaluation at all levels.
7. To strengthen partnerships among different stakeholders.
8. To strengthen management of leprosy complications like reactions and disability prevention, and rehabilitation.
9. To coordinate with neighboring states of India in the management, reporting, and referral of cases from border areas.
10. To promote research and innovations.

**Four Strategic Pillars:**

1. Implement the national leprosy roadmap for zero leprosy across all levels-national, provincial, and local.
2. Scale up leprosy prevention alongside integrated active case detection.
3. Manage leprosy and its complications and prevent new disability.
4. Combat stigma and ensure human rights are respected.

S.N.	Indicator	Baseline (2019)	Current status (2023/2024)	SDG Target (2030)
1.	Number of annual leprosy cases (% reduction from baseline)	3282	2472 (25% )	985 (70% )
2.	Rate of new leprosy cases with G2D (per million population)	5.3	6.3	zero
3.	New child leprosy case detection rate (per million child population)	30	17.3	<1
4.	Number of child cases among new leprosy cases(% child case proportion among new leprosy cases)	260 (7.9% )	136 (5.5% )	10 (1% )
5.	Number of child G2D among new child leprosy cases	2 of 260 new child cases	2 of 136 new child cases	0
6.	Number of municipalities with zero leprosy cases	65/753	353/753	565/753

### 3.2.4 Indicators

Nepal declared itself with the Leprosy elimination status in January 2010, and since then has successfully sustained elimination at the national level. Similarly, Rolpa has also declared and sustained the elimination status of leprosy (defined as: reducing the Prevalence <1 case/10,000 population) till now.

#### 3.2.4.1 Major indicators of the National Leprosy Program in the Rolpa district

Indicators	Fiscal Years		
	2079/80	2080/81	2081/82
Total Leprosy New cases	5	9	3
New case detection rate of leprosy	0.21	0.39	0.13
Prevalence of leprosy per 10,000 population	0.21	0.39	0.13
Proportion of female cases among new cases detected	40	22	67
Proportion of children(0-14 years) among new cases detected	0	0	0
% of new cases that are MB	100	88.89	100
Percentage of relapse cases of leprosy	0	1	0

The number of new leprosy cases decreased in fiscal year 2081/82 B.S. in comparison to the last fiscal year. The total number of new leprosy cases was three, one each from Sunchhari Rural Municipality, Rolpa Municipality, and Sunil Smriti Rural Municipality, and 100% of the cases were Multi-Bacillary (MB). The new case detection rate of leprosy was 0.13 in fiscal year 2081/82 B.S., and the proportion of female cases among new cases detected was 67%.

### 3.2.5 Major activities in Rolpa district in FY 2081/82

- Family diagnosis of patients and their neighbors
- Contract tracing of the family members of leprosy cases.
- Transportation cost provided to RFT cases.
- Conducted an orientation program targeting lab personnel and health workers, focusing on diagnosis, treatment, and management of cases.
- Regular supply of medicine and commodities
- IEC/BCC intervention and World Leprosy Day celebration
- Supportive supervision and monitoring of the program

### 3.2.6 Issues, Recommendations, and Responsibilities

Issues/Challenges	Recommendations	Responsibilities
Difficulty in managing reactions and complicated leprosy cases	The number of referral centers should be increased	DoHS/MoH
Lack of orientation among health workers for the diagnosis and treatment of leprosy cases	Mandatory to provide basic leprosy training to the newly recruited health workers.	DoHS/MoH/PHD
Difficulties in the diagnosis of new leprosy cases	Skin Screening camp should be conducted with a dermatologist in a remote area.	PHD/MOH/CSSD

### 3.3 Malaria Elimination Program

#### 3.3.1 Introduction

Malaria is a mosquito-borne disease that poses a significant public health challenge in Nepal. It is primarily transmitted to humans through bites from infected female *Anopheles* mosquitoes. Previously Terai region of Nepal was the most affected area, but nowadays, cases have been reported in hilly and mountainous regions. Malaria transmission in Nepal is seasonal, peaking before and after the monsoon.

To achieve malaria elimination, Nepal adopted a micro-stratification approach in 2066/67 (2010), starting at the district level and later extending to the ward level within local-level government units (LLGs). This method helps better identify and address the population at risk at the community level. The process involves analyzing recent malaria data, climate patterns, ecological factors, key vector species, and human movement vulnerabilities. Recommendations from the Epidemiology and Disease Control Division (EDCD) and the Malaria Technical Working Group (TWG), this approach has been revised and updated in 2068/69 (2012), 2072/73 (2016), and 2074/75 (2018).

In 2080/81, the updated micro-stratification categorized wards into high, moderate, low, and no risk. Lumbini province consists of 11 high-risk wards out of a total of 25 high-risk wards.

#### 3.3.2 Vision, Mission, Goal, and Objectives

National Malaria Strategic Plan (NMSP 2070/71 -2082/83 (2014 – 2025) which was developed in 2069/70 (2013) with pre-elimination focus was updated in 2076/77 (2020) based on the WHO Global Technical Strategy for malaria elimination 2072/73-2087/88 (2016 – 2030), federalization of the health system, disease epidemiology and midterm malaria program review-2073/74 (2017). Nepal is also part of the global E-2082/83 (E-2025) countries to attain “Malaria Elimination in Nepal by 2082/83 (2025)”.

**Vision:** To make Nepal “Malaria Free” by 2025.

**Mission:** To provide universal access to quality-assured comprehensive malaria services and move towards malaria elimination.

**Goal:** Reduce the indigenous cases to zero by 2022 and sustain zero malaria mortality.

**Objectives:** The objectives of the National Malaria Strategic Plan are to consolidate the gains and sustain its impact of the previous strategic plan, which primarily focused on malaria pre-elimination. The updated NMSP (2014-2025) will attain the elimination goals through the implementation of the following specific objectives:

1. Strengthen surveillance and strategic information on malaria for effective decision-making.
2. Ensure effective coverage of vector control interventions in the targeted malaria risk areas.
3. Ensure universal access to quality-assured diagnosis and effective treatment for malaria.
4. Develop and sustain support from leadership and communities towards malaria elimination.
5. Strengthen programmatic, technical, and managerial capacities towards malaria elimination.

### **3.3.3 Role of Health Office**

At the district level, the health office provides support for the implementation of activities, ensures quality through technical support, and facilitates the supply of malaria commodities. The health office coordinates with the local bodies and organizes review meetings periodically to track program progress, including vector control disease programs. It also regularly conducts field visits in malaria risk areas for supervision and monitoring of the field activities, assessing stock situation of malaria rapid diagnostic test kits (RDTs) and anti-malarial drugs, as well as other related commodities, and reviewing the recording & reporting of malaria data.

Altogether, there are four Malaria Microscopic Centers in the Rolpa district, i.e., Rolpa Hospital, Holeri PHCC, Sulichaur PHCC, and Nerpa HP. The District has planned to expand more microscopic centers and promote tests from the health post level by RDT test kits.

### 3.3.4 Major Indicators

Indicators (Number)	Fiscal Year		
	2079/80	2080/81	2081/82
Total number of blood slide examinations	1126	2681	4713
Annual Blood Examination Rate (ABER) of malaria in the at-risk population	0	1.16	0
Malaria annual parasite incidence per 1,000 population	0	1.16	0
Total Malaria Positive cases	1	0	3
% of imported cases among positive malaria cases	100	0	100
% of indigenous cases among positive malaria cases	0	0	0
Deaths due to malaria	0	0	0

The total number of blood slide examinations has been in an increasing trend since the last three fiscal years. There were three malaria-positive cases in fiscal year 2081/82 B.S., and all of them were imported cases.

### 3.3.5 Major activities performed during FY 2081/82

- A sample collection of suspected malaria cases and a test was performed by rapid diagnostic test kits and microscopy.
- Conducted case-based investigation in the positive cases area, Case-based treatment, and referral
- Celebrated World Malaria Day on 25 April

### 3.3.6 Issues, Recommendations, and Responsibilities

Issues/Challenges	Recommendations	Responsibility
Low blood slide collection of suspected malaria cases	Blood slide collection should be increased for the suspected cases by HFs	R/M, HFs, HO
Lack of orientation of basic Malaria and Malaria Microscopy Training	Training or orientation needs to be planned for newly recruited health workers and laboratory personnel	MoH/HD/EDCD
Lack of malaria case-based investigation	Orientation to local-level health staff and elected bodies to sensitize the importance	MoH/HD/EDCD

### 3.4 HIV and STIs Control and Management Program

#### 3.4.1 Introduction

The first case of Human Immunodeficiency Virus (HIV) in Nepal was identified in 2044/45 BS (1988 AD). The National Center for AIDS & STD Control (NCASC) was established in 2050 BS, which marked the formal beginning of a coordinated national response to HIV/AIDS and STDs. Later, the National Policy on Acquired Immunodeficiency Syndrome (AIDS) and Sexually Transmitted Diseases (STDs) Control was introduced in 2052 BS (1995 AD), which was Nepal's first policy addressing these issues. Nepal launched its first National HIV/AIDS Strategy on 2058/59 BS (2002 AD), focusing on prevention, treatment, care, and support for affected populations. In 2060 BS (2003 AD), Antiretroviral therapy (ART) was introduced in Nepal, providing free treatment to people living with HIV. The National Policy on HIV and Sexually Transmitted Infections (STIs) was revised and updated on 2067/68 BS (2011 AD) to address the dynamic nature of the epidemic. Similarly, Nepal adopted the Fast Track Targets on 2072 BS (2016 AD) to end AIDS as a public health threat by 2030 AD, aligning with the global Sustainable Development Goals (SDGs).

The HIV epidemic in Nepal has evolved from a low prevalence to a concentrated epidemic. The prevalence of HIV infection in the general population is relatively low, but in specific subpopulations, the prevalence is much higher. The HIV epidemic in Nepal remains largely concentrated among key populations, including People Who Inject Drugs (PWID), sex workers and their clients, Men who have sex with men (MSM) and Transgender (TG) people, Male Labor Migrants (MLM) and their spouses, and prison inmates.

#### 3.4.2 Vision, Mission, Goal, Indicators, Targets, and Priorities

The National HIV Strategic Plan (NHSP) 2021–2026 builds upon the achievements of the previous strategic plan and aligns with global commitments, including the Sustainable Development Goals and UNAIDS strategies 2021-2026 to meet the global goal of 95-95-95 by July 2026, including commitments to Fast-Tracking for ending the AIDS epidemic as a public health threat by 2030. The plan emphasizes a people-centered approach, grounded in human rights and health equity, aiming to significantly reduce new HIV infections and AIDS-related deaths while improving the quality of life for people living with HIV (PLHIV).

**Vision:** Ending the AIDS epidemic in Nepal by 2030.

**Mission:** To provide inclusive, equitable, and accessible services throughout the HIV care continuum.

**Goals:**

1. To prevent new HIV infections
2. To improve HIV related health outcomes of PLHIV
3. To reduce HIV related inequalities among PLHIV and KPs

**Key indicators to be achieved by 2026 and 2030:**

Key Indicators	Baseline (2019)	Target (2026)	Target (2030)
HIV prevalence in young people aged 15-24 years	0.02	0.02	0.01
HIV incidence rate per 1000 population	0.03	0.02	0.015

**Targets By 2026:**

1. Identify 95 % of the estimated PLHIV
2. Treat 95 % of people diagnosed with HIV
3. Attain viral load suppression for 95 % of PLHIV on ART
4. Reduce 90% of new HIV infections (baseline as of 2010)
5. Eliminate vertical transmission of HIV
6. Achieve a case rate of congenital syphilis of  $\leq 50$  per 100,000 live births

**Priorities:**

1. Accelerating HIV prevention services among key populations.
2. Expanding innovative and effective testing approaches with universal access to comprehensive treatment, care, support, VL testing, and suppression services.
3. Elimination of vertical transmission and syphilis.
4. Scaling up of HIV-sensitive social protection services to key and vulnerable populations.
5. Addressing human rights and gender in HIV response.
6. Strengthening effective, inclusive, and accountable HIV governance.

**3.4.3 Major HIV services in Rolpa district**

In Rolpa District, there is one HTC center, one ART center, one PMTCT site, and 74 community-based PMTCT sites, which are responsible for HIV Testing and Counseling and Treatment. The major HIV services in the Rolpa district are:

1. HIV testing services and STI management
2. Community-Based/Prevention of mother-to-child transmission
3. HIV treatment, care, and support services

### 3.4.4 Indicators

Indicators	2079/80	2080/81	2081/82
Number of key populations who received an HIV test and know their status	3604	242	264
New HIV Cases	1	0	0
Total HIV Cases	1	0	2
% of eligible clients currently receiving ART	99	100	100
Number of pregnant mothers tested for HIV	1	2	1
% of Pregnant women who tested for HIV at an ANC checkup	63.5	85.3	91
Number of pregnant mothers with HIV	1	2	1
Number of HIV positive pregnant mothers enrolled in ART	1	2	1

The number of key populations who received an HIV test and know their status was more than the last fiscal year and was 264 in fiscal year 2081/82 B.S. in the Rolpa district. There were a total of two HIV cases in Rolpa district in the fiscal year 2081/82 B.S.

### 3.4.5 Major activities in FY 2081/82 in Rolpa district

- Establishing linkages and integration among HIV services and other health services for quality HIV prevention, treatment, and monitoring of treatment adherence
- HIV Counseling and Testing Services (static and camp) and community-based testing services
- Quarterly ART management committee meeting in a hospital setting
- Celebration of World AIDS Day and Condom Day
- Regular monitoring and supervision of the program and uninterrupted supply of commodities (Test Kits, ARV medicine, and others)
- Conducted community-based HIV/TB screening and testing for migrant worker and their spouses

### 3.4.6 Issues, Recommendations, and Responsibilities

<b>Issues/Challenges</b>	<b>Action to be taken</b>	<b>Responsibilities</b>
Poor supply of STIs and opportunistic infections (OIs) medicines	Consistent supply of STIs and OIs medicines	NCASC, PHLMC
Fewer HTC sites	All PHCs need to be listed as an HTC site to increase the test numbers	NCASC
Poor HIV/STI services recording and reporting in the hospital setting, especially in the OPD	Proper linkages of OPD and laboratory services to HTC and ART services to improve quality recording and reporting	LLG, HF, Hospital
Inadequate supply of HIV Test kits	Should supply an adequate quantity of HIV test kits	NCASC, PHLMC
The PMTCT site could not expand in all BHSC due to untrained human resources.	Should conduct PMTCT training to untrained Health workers	NCASC, HTC

## 3.5 Dengue Control Program

### 3.5.1 Introduction

Dengue, a mosquito-borne illness transmitted by *Aedes aegypti* and *Aedes albopictus*, is endemic across most provinces in Nepal. First identified in 2060/61 BS (2004 AD), dengue cases have steadily increased, particularly in tropical lowland areas and subtropical hilly regions, including Kathmandu. Several outbreaks have occurred between 2062/63 BS (2006 AD) and 2078/79 BS (2022 AD), highlighting the disease's persistence and spread across various districts.

Entomological surveillance by the EDCD from 2062/63 to 2066/67 BS (2006–2010 AD) detected *A. aegypti* in five peri-urban areas of the Terai (Kailali, Dang, Chitwan, Parsa, and Jhapa), confirming local transmission. Between 2068/69 and 2071/72 BS (2012–2015 AD), cases were reported intermittently, followed by annual outbreaks in different districts. A major outbreak occurred in 2075/76 BS (2019 AD), affecting 68 out of 77 districts, with 17,992 cases reported.

During the COVID-19 pandemic (2076/77–2077/78 BS or 2020–2021 AD), the number of dengue cases declined, but the 2079 B.S. (2022 AD) outbreak was the largest recorded in Nepal, with 54,784 cases and 88 deaths. Dengue has now become a significant public health concern, with cases reported year-round in all 77 districts. Current programs aim to reduce dengue-related mortality through targeted.

A recent study by the Vector Borne Disease Research and Training Center (VBDRTC) has confirmed that both *Aedes aegypti* and *Aedes albopictus* mosquitoes are responsible for transmitting dengue in Nepal. Entomological surveillance conducted in three cities-Kathmandu, Lalitpur, and Ghorahi in 2079 BS (2022 AD) found the presence of both mosquito species in Lalitpur and Ghorahi.

In 2062/63 BS (2006 AD), a collaborative study by the EDCD and NPHL identified all four dengue virus subtypes (DEN-1, DEN-2, DEN-3, and DEN-4) circulating in Nepal. However, in the 2079 BS (2022 AD) serotyping study conducted by EDCD and NPHL, the predominant virus was DENV1, followed by DENV3 and DENV2, with no positive samples for DENV4.

### 3.5.2 Goal, Objectives, and Strategies

**Goal:** To reduce the morbidity and mortality due to dengue fever, dengue hemorrhagic fever (DHF), and dengue shock syndrome (DSS).

**Objectives:**

1. To develop an integrated vector management (IVM) approach for prevention and control.
2. To develop capacity on diagnosis and case management of dengue fever, DHF, and DSS.
3. To intensify health education and IEC activities, to dengue outbreaks.

**Strategies:**

1. To strengthen the surveillance system for prediction, early detection, preparedness, and early response
2. Early case detection, diagnosis, management, and reporting of dengue fever
3. Regular monitoring of dengue fever surveillance through the EWARS
4. Mosquito vector surveillance in municipalities
5. The integrated vector control approach, where a combination of several approaches is directed towards containment and source reduction

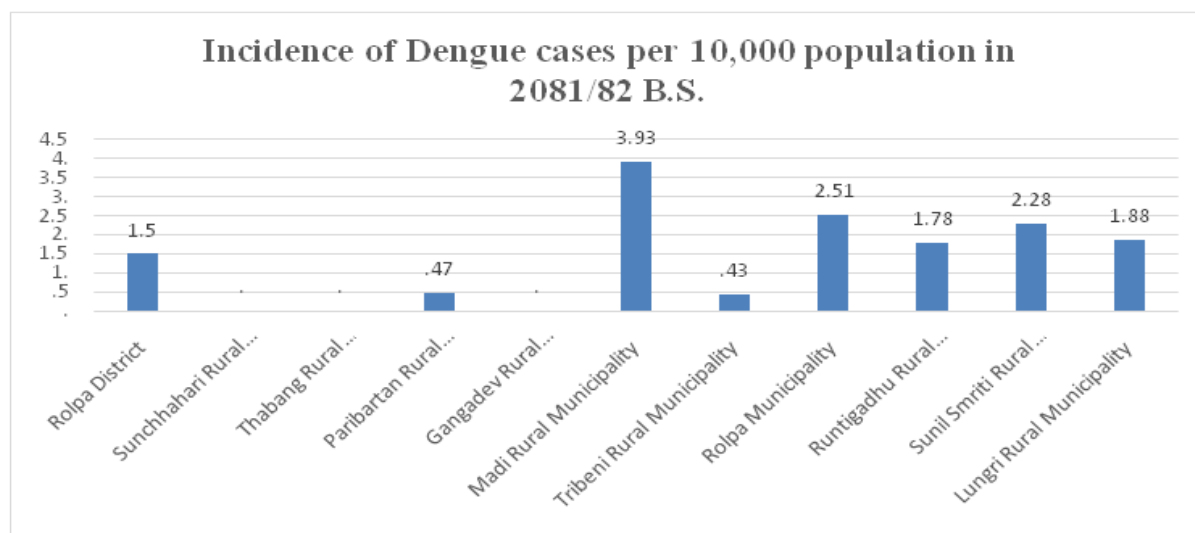
### 3.5.3 Major Indicators

#### 3.5.3.1 Three-year trend of key indicators in Rolpa District

Indicators	Fiscal Year		
	2079/80	2080/81	2081/82
Incidence of Dengue cases per 10,000 population	0.21	0.95	1.5
Total Dengue Tested	99	385	1039
Dengue Fever Cases	5	22	35

The incidence of dengue cases is in an increasing trend since the last three fiscal years, along with the number of dengue cases that were tested and dengue fever cases.

### 3.5.3.2 Palika-wise distribution of new Dengue cases in Rolpa District



The incidence of Dengue cases per 10,000 population in fiscal year 2081/82 B.S. is 1.5, with the highest incidence in Madi Rural Municipality (3.93) and zero cases in Sunchhahari and Thabang Rural Municipality.

### 3.5.4 Major activities in FY 2081/82

- Conducted ‘Search and Destroy’ activities at different communities to search for the potential breeding sites of Aedes mosquitoes and destroy them
- Routine surveillance of Dengue cases through EWARS (sentinel sites)
- Distribution of rapid diagnostic test kits (IgM) received from PHLMC
- Recording, reporting, and data verification

### 3.5.5 Issues, Recommendations, and Responsibilities by HO

Issues/Challenges	Action to be taken	Responsibilities
Limited community awareness of dengue prevention	Implement mass awareness campaigns through media and community mobilization.	FCHVs, HF, LLG
Poor waste management is contributing to mosquito breeding	Promote proper solid waste disposal and water container management	FCHVs, HF, LLG
Delay in case reporting and data sharing	Strengthen surveillance and ensure timely data reporting	HF, LLG, HO
Inadequate supply of dengue test kits	Ensure timely procurement and distribution of dengue test kits.	LLG, HO, PHD, MoH
Lack of trained health workers in dengue case management	Conduct training on dengue diagnosis and management	HO, PHD, PHTC

### 3.6 Kala-azar Elimination Program

#### 3.6.1 Introduction

Kala-azar, a severe form of leishmaniasis caused by *Leishmania* parasites transmitted by infected female sandflies, leads to prolonged fever, weight loss, and organ enlargement, and can be fatal within two years if untreated.

Nepal aims to eliminate Kala-azar by maintaining an annual incidence rate of less than 1 case per 10,000 people at the district level, with a case fatality rate below 1%. This target was achieved in 2013 in endemic districts and has been sustained since then in program districts.

**Goal:** The goal of the kala-azar elimination program is to contribute to the mitigation of poverty in kala-azar endemic districts of Nepal by reducing the morbidity and mortality of the disease and assisting in the development of equitable health systems.

**Target:** Reduce the incidence of kala-azar to less than 1 case per 10,000 population at the district level.

#### Objectives:

- Reduce the incidence of kala-azar in endemic communities with special emphasis on poor, vulnerable, and unreached populations.
- Reduce case fatality rate to ZERO.
- Detect and treat Post-Kala-azar Dermal Leishmaniasis (PKDL) to reduce the parasite reservoir.
- Prevent and manage Kala-azar HIV–TB co-infections.

#### Strategies:

- Early diagnosis and complete treatment
- Integrated vector management
- Effective disease and vector surveillance
- Social mobilization and partnerships
- Improve program management
- Clinical and implementation research

#### 3.6.2 Indicators

Major Indicators	Fiscal Year		
	2079/80	2080/81	2081/82
Incidence of Kala-azar	4.3	2.4	0
Total number of Kala-azar cases	0	1	0
Deaths due to Kala-azar	0	0	0

The incidence of Kala-azar per 10,000 population is in a decreasing trend and is 0 in the fiscal year 2081/82 B.S. Similarly, the total number of Kala-azar cases and deaths due to Kala-azar is 0 in fiscal year 2081/82 B.S.

### 3.6.3 Major activities in FY 2081/82

- Awareness activities were done among local stakeholders, elected bodies, and school children.
- Supportive supervision was done in health facilities at the local level.
- Recording, reporting, and data verification.

### 3.6.4 Issues, Recommendations, and Responsibilities:

Issues/Challenges	Recommendations	Responsibilities
Weak case detection & delayed diagnosis	Strengthen active case detection (ACD) during high-risk seasons; train health workers to use and report rK39 tests.	HO, LLG, HF
Under-reporting, delayed notification, poor data quality	Enforce weekly case reporting; monthly data review meetings with peripheral facilities.	HO, LLG, HF
Unavailable rK39 tests, antileishmanial drugs at the peripheral level	Maintain buffer stocks for the Kala-azar Elimination program at the local level	PHD, HO, LLG

### 3.7 Scrub Typhus

#### 3.7.1 Introduction

Scrub typhus is a vector-borne infectious disease caused by *Rickettsia Oriental tsutsugamushi* and transmitted to humans through the bite of infected larval mites, which may leave a characteristic black scar that is useful for making a clinical diagnosis of scrub typhus. There is no human-to-human transmission of scrub typhus. This disease is one of the Neglected Tropical Diseases (NTDs) reported from many Asian countries, including Nepal. The presence of scrub typhus in Nepal was officially confirmed in 2015, when 101 cases were reported from 16 districts, among them, 8 cases died. Nepal again suffered from a scrub typhus outbreak in 2016 with more than 800 reported cases and 14 deaths. Now total of 47 districts are affected by the epidemic.

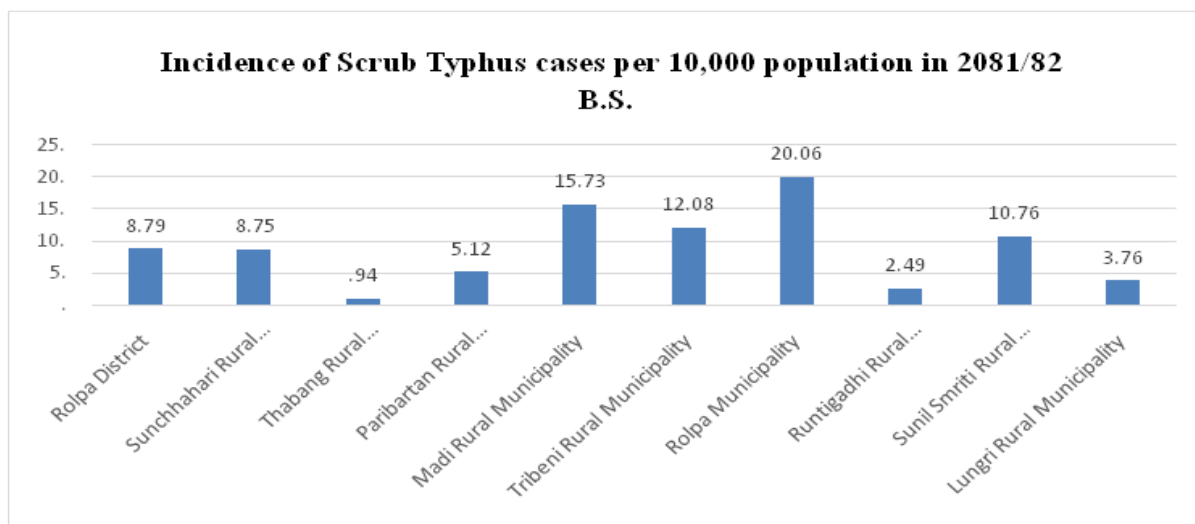
#### 3.7.2 Indicators

##### 3.7.2.1 Three-year trend of major Indicators in the Rolpa district

Indicators	Fiscal Year		
	2079/80	2080/81	2081/82
Total Scrub Typhus Tested	110	297	1119
Total cases of Scrub Typhus reported	8	52	205
Incidence of Scrub Typhus cases per 10,000 population	0.33	0.95	8.79

The number of tests in FY 2081/82 is very high compared to the previous fiscal year, and the number of Scrub typhus cases detected increased in comparison to the previous fiscal year. Similarly, the incidence of scrub typhus cases per 10,000 population decreased in comparison to the last fiscal year.

##### 3.7.2.2 Palika-wise distribution of new Scrub Typhus cases in Rolpa district



The incidence of scrub typhus per 10,000 population in fiscal year 2081/82 B.S. is 8.79, with the highest incidence in Rolpa municipality (20.06) and the lowest incidence in Thabang Rural Municipality (0.94).

### 3.7.3 Major activities in FY 2081/82

- Orientation and awareness campaign done for prevention and control of scrub typhus through FM radio dissemination, and a stakeholders meeting.
- Distribution of rapid diagnostic test kits (IgM), which were received from PHLMC
- Awareness activities were done among local stakeholders, elected bodies, and school children.
- Recording, reporting, and data verification.

### 3.7.4 Issues, Recommendations, and Responsibilities:

<b>Issues/Challenges</b>	<b>Recommendations</b>	<b>Responsibilities</b>
Lack of rapid diagnostic test kits (IgM)	Ensure the availability of rapid diagnostic test kits (IgM)	PHLMC
Miss the cases to report EWARS for Scrub Typhus from OPD	Orientation and review meeting for medical officers and clinicians regarding NTDs	EDCD/MOH

## 3.8 Non-Communicable Diseases Prevention and Treatment Programs

### 3.8.1 Introduction

The burden of Non-Communicable Diseases (NCDs) has been showing an increasing trend in Nepal. The deaths due to NCDs were 71.1% of total deaths in 2019, which increased from 63.7% in 2015. Cardiovascular diseases (CVDs) accounted for 24%, Chronic obstructive pulmonary diseases (COPD) 16.3% and cancer 11.1% of total deaths. Total DALYs due to NCDs were 61.2% of which CVDs shared 11.9%, cancer 11.9% and COPD 7.3%<sup>1</sup>. Expenditure on NCDs was also the highest among disease-specific health expenditure (39.5%). Among Out-of-Pocket expenditures, NCDs accounted for 40.3% of total household OOP health expenditure.

Factors contributing to this rising burden include increasing life expectancy, demographic and epidemiological transitions, rapid urbanization, and lifestyle changes. The growing disease burden has been linked to a decline in quality of life, an increase in Disability-Adjusted Life Years (DALYs), and catastrophic health expenditures. The rising disease burden in Nepal is driven by increasing life expectancy, demographic and epidemiological transitions, urbanization, and lifestyle changes. This has led to a decline in quality of life, higher DALYs, and catastrophic health costs. STEPS surveys (2008 vs. 2019) show a rise in insufficient physical activity (3.5% to 6.5%), high blood sugar (3.6% to 8.5%), and elevated BMI (17.1% to 24.3%) among adults. Households spent 38.8% (2018/19) and 40.3% (2019/20) of their total out-of-pocket (OOP) expenses on NCDs, while injury-related OOP spending was 13.0% and 11.7%, respectively.

### 3.8.2 Vision, Mission, Goal, Objectives, and Targets

GoN has prioritized NCDs and has strategic planning based on the National Multi-sectoral Action Plan II (MSAP II) for NCDs (2021-2025).

**Vision:** Healthy and productive citizens free from non-communicable diseases.

**Mission:** To improve the standard of living of Nepalis by reducing the suffering and premature mortality caused by non-communicable diseases through prevention and control.

**Goal:** To reduce the burden of NCDs in Nepal through a “whole of government” and “whole of society” approach

**Objectives:**

1. To reduce risk factors for non-communicable diseases and address the social determinants inherent in various sectors.
2. To strengthen a citizen-friendly health system for effective prevention and control of non-communicable diseases.
3. To establish a monitoring, evaluation, and assessment system for evidence-based policies and programs.

**Target:** To reduce the overall premature mortality rate from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases by 25% by 2025 and by 33% by 2030.

### **3.8.3 Key programs for management of NCDs**

#### **3.8.3.1 Nepal PEN program**

The Package of Essential NCDs (PEN) and HEARTS (Healthy-lifestyle counseling; E=Evidence-based protocols; A=Access to essential medicines and technologies; R=Risk-based CVD management; T=Team-based care; S=Systems for monitoring) toolkit enhances fairness and effectiveness in primary healthcare for limited-resource settings, identifying essential technologies, medications, and risk prediction tools. The WHO PEN program provides cost-effective protocols and frameworks for integrating key NCD interventions into primary care, strengthening health systems through prioritized, resource-efficient, and user-friendly tools, and is implemented across all seven provinces and 77 districts of Nepal.

#### **3.8.3.2 Hypertension Care Cascade Initiative Nepal (HCCIN)**

Hypertension is a major public health concern in Nepal, affecting over 25% of the adult population. The Hypertension Care Cascade Initiative Nepal (HCCIN) aims to strengthen primary healthcare by improving screening, treatment, and follow-up for hypertension and diabetes through protocol-based care, workforce capacity-building, and sustainable local ownership.

Launched in May 2023 from Kavrepalanchok by the MoHP with support from NORAD and WHO, the HCCIN program enhances hypertension and diabetes care through evidence-based screening, diagnosis, treatment, and follow-up at the primary healthcare level, aiming to reach 1.5 million people by 2025 with support from academia, peer coaching, supervision, mentoring, and e-health strategies.

#### **3.8.3.3 PEN-Plus Program in Nepal**

The MoHP, in partnership with Kathmandu Institute of Child Health (KIOCH) and supported by the NCDI Poverty Network and UNICEF Nepal, launched the PEN-Plus program in six districts (Jhapa, Bardiya, Dailekh, Bajhang, Gulmi, and Siraha) to bridge the gap between chronic care services and the needs of underserved children and young adults.

This integrated health service model bridges primary and tertiary care, improving access to quality chronic care for severe NCDs at district hospitals. It focuses on conditions such as Type 1 Diabetes, Rheumatic Heart Disease, Congenital Heart Disease, Childhood Asthma, Hemoglobinopathies, Cancers, and Neurodevelopmental Disorders. The PEN-Plus initiative strengthens district hospitals by training healthcare providers, providing necessary equipment, and offering social support to patients. It aims to enhance treatment accessibility at the district level, reduce caseloads at tertiary hospitals, and contribute to Universal Health Coverage (UHC) and the Sustainable Development Goals (SDGs).

### **3.8.3.4 National Cancer Control Strategy (2024-2030)**

The National Cancer Control Strategy (NCCS) aims to reduce cancer burden and mortality in Nepal by ensuring accessible, affordable, and equitable prevention, early detection, treatment, and palliative care through multi-sectoral collaboration and an integrated, holistic, and cost-effective approach.

### **3.8.3.5 Behavior change communication (BCC) on NCD risk factors**

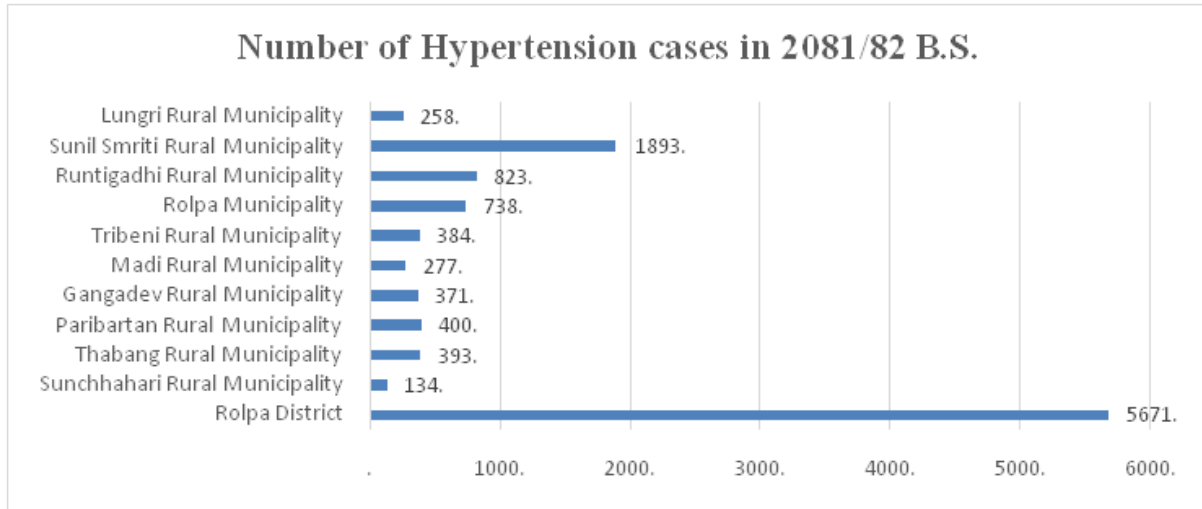
Additionally, the preventive and promotive awareness-raising activities on risk factors for NCDs, like alcohol and tobacco, are led by NHEICC.

## **3.8.4 Indicators**

### **3.8.4.1 Three-year trend of major Indicators of NCDs in Rolpa district**

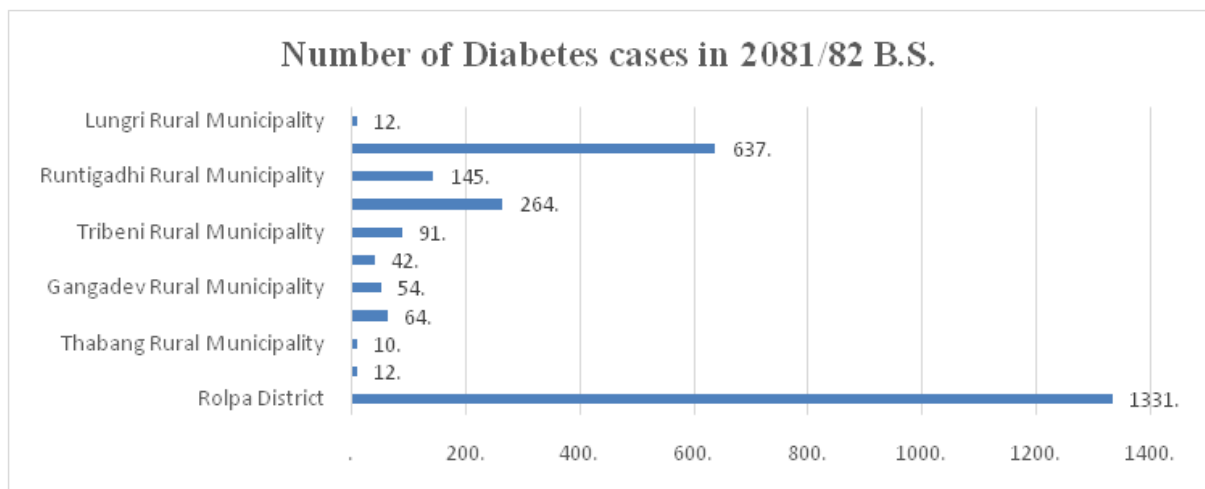
Indicators	Fiscal Year		
	2079/80	2080/81	2081/82
Number of total Hypertension Cases New	2486	4727	5671
Number of CVD cases	27	26	24
Number of Diabetes cases	744	1585	1331
Number of COPD cases	1248	1648	1401
Number of Asthma cases	977	1259	1229
Number of Alcohol Use Disorder cases	9	45	60
Number of Bites cases	335	411	443
Number of RTI cases	264	512	462
Number of Fall cases	1319	2430	2200
Number of Drowning cases	1	7	4
Number of Burn cases	368	467	469
Number of Self-Harm cases	14	76	19
Number of Violence cases	45	87	62
Number of cancer cases	8	5	4

### 3.8.4.2 Palika-wise distribution of total hypertension cases in Rolpa district



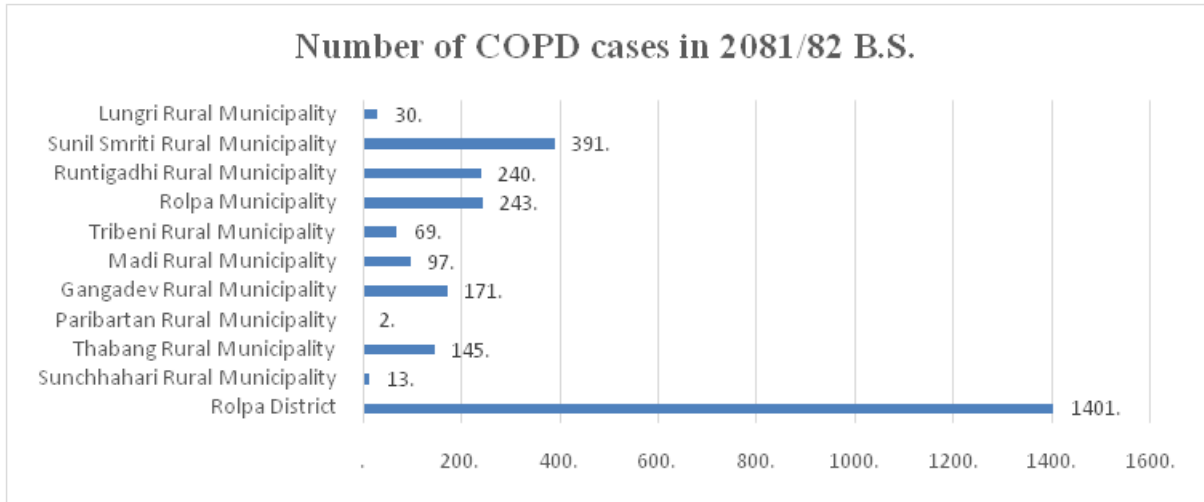
The total number of hypertension cases in Rolpa district was 5671 in fiscal year 2081/82 B.S., with the highest number of cases in Sunil Smriti Rural Municipality (1893) and the lowest number of cases in Sunchhahari Rural Municipality (134).

### 3.8.4.3 Palika-wise distribution of diabetes cases in Rolpa district



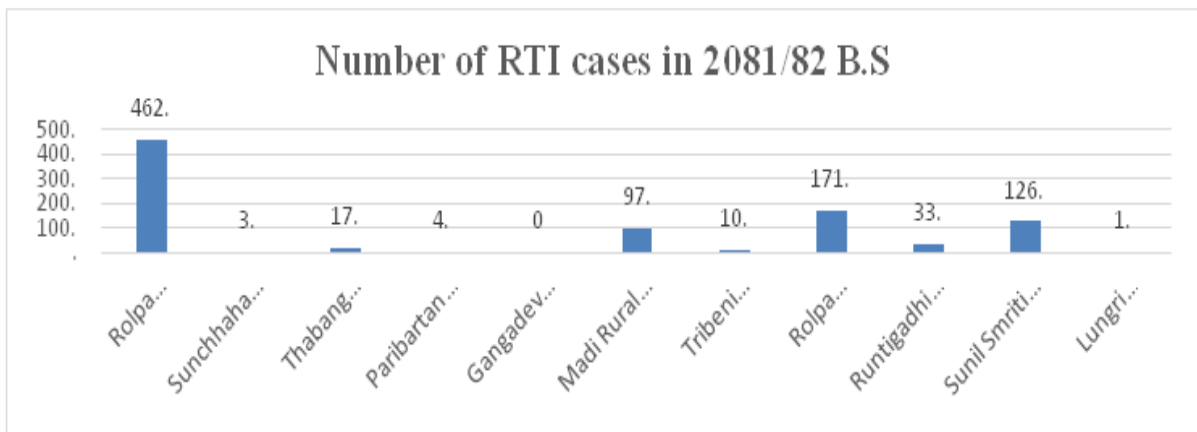
The total number of diabetes cases in Rolpa district was 1331 in fiscal year 2081/82 B.S., with the highest number of cases in Sunil Smriti Rural Municipality (637) and the lowest number of cases in Thabang Rural Municipality (10).

### 3.8.4.4 Palika-wise distribution of COPD cases in Rolpa district



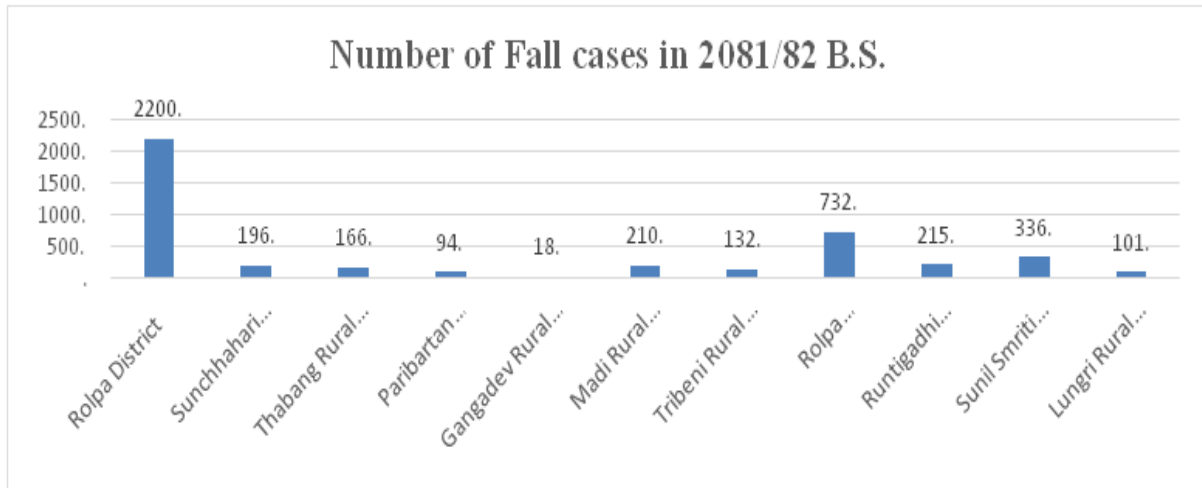
The total number of COPD cases in Rolpa district was 1401 in fiscal year 2081/82 B.S., with the highest number of cases in Sunil Smriti Rural Municipality (391) and the lowest number of cases in Paribartan Rural Municipality (2).

### 3.8.4.5 Palika-wise distribution of RTI cases in Rolpa district



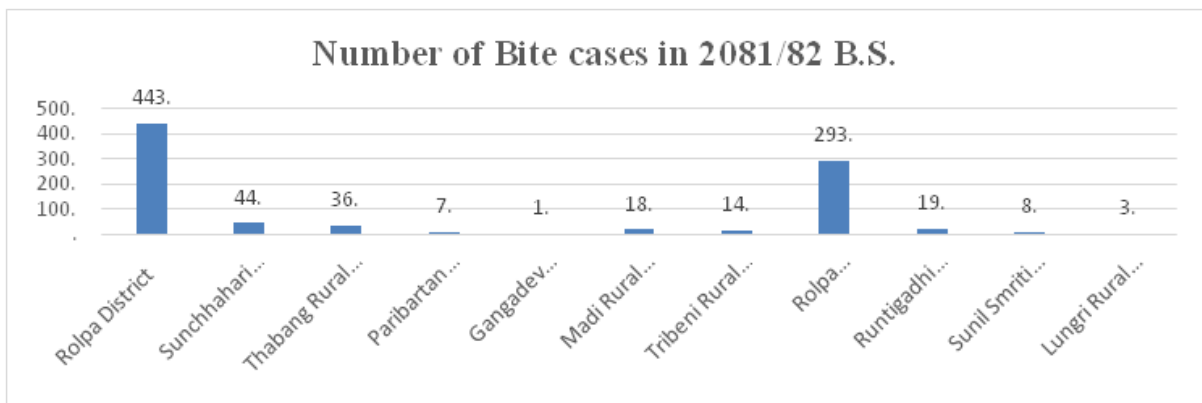
The total number of RTI cases in Rolpa district was 462 in fiscal year 2081/82 B.S., with the highest number of cases in Rolpa Municipality (171) and the lowest number of cases in Gangadev Rural Municipality (0).

### 3.8.4.6 Palika-wise distribution of Fall cases in Rolpa district



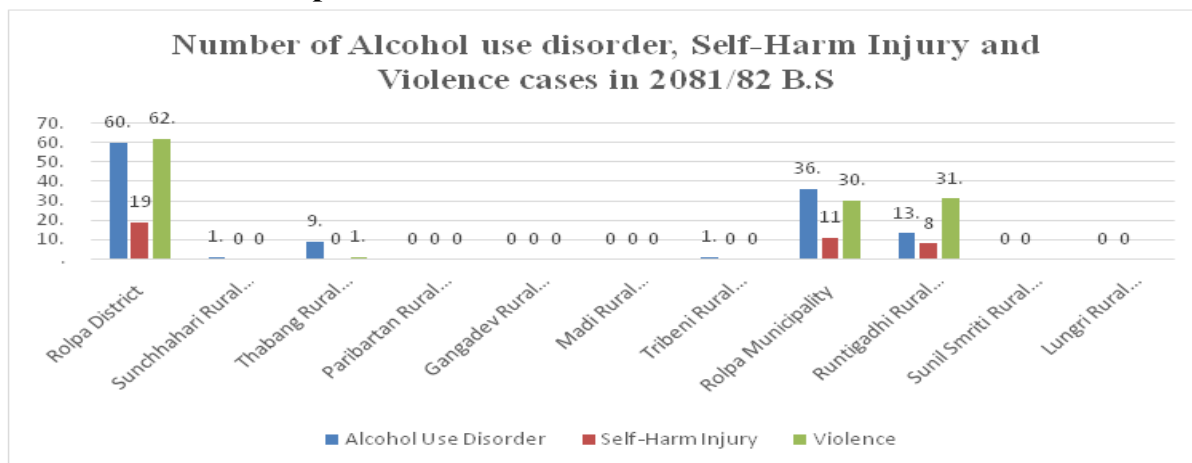
The total number of Fall cases in Rolpa district was 2200 in fiscal year 2081/82 B.S., with the highest number of cases in Rolpa Municipality (732) and the lowest number of cases in Gangadev Rural Municipality (18).

### 3.8.4.7 Palika-wise distribution of Bite cases in Rolpa district



The total number of Bite cases in Rolpa district was 443 in fiscal year 2081/82 B.S., with the highest number of cases in Rolpa Municipality (293) and the lowest number of cases in Gangadev Rural Municipality (1).

### 3.8.4.8 Palika-wise distribution of Alcohol use disorder, self-harm, and violence cases in Rolpa district



The total number of Alcohol use disorder cases in Rolpa district was 60 in fiscal year 2081/82 B.S., with the highest number of cases in Rolpa Municipality (36). Similarly, the total number of self-harm injury cases in Rolpa district was 19 in fiscal year 2081/82 B.S., with the highest number of cases in Rolpa Municipality (11). Also, the total number of violence cases in Rolpa district was 62 in fiscal year 2081/82 B.S., with the highest number of cases in Runtigadhi Rural Municipality (31).

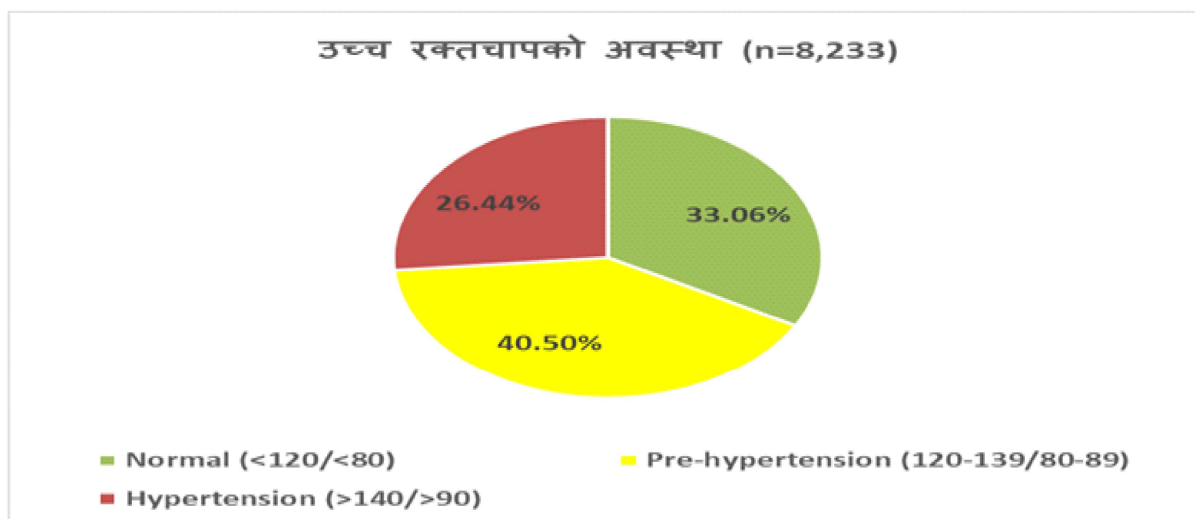
### 3.8.4.11 Palika-wise distribution of beneficiaries receiving medical assistance from the Province Government in FY 2081/82 in Rolpa district

Details of Rs. 200,000 recommended to the Province Government for medical assistance from the local level (Fiscal Year 2081/82)				
Name of LLG	Disease/Condition			Total
	Kidney Transplant	Cancer	Valve Transplant	
Sunchhachari RM		1		
Thabang RM		1		
Paribartan RM		2		
Gangadev RM		5		
Madi RM	1	5		
Tribeni RM		4		
Rolpa Mun	1	4		
Runtigadhi RM	1	4	1	
Sunilsmriti RM		3		
Lungri RM	1	6		
<b>Total</b>	<b>4</b>	<b>35</b>	<b>1</b>	

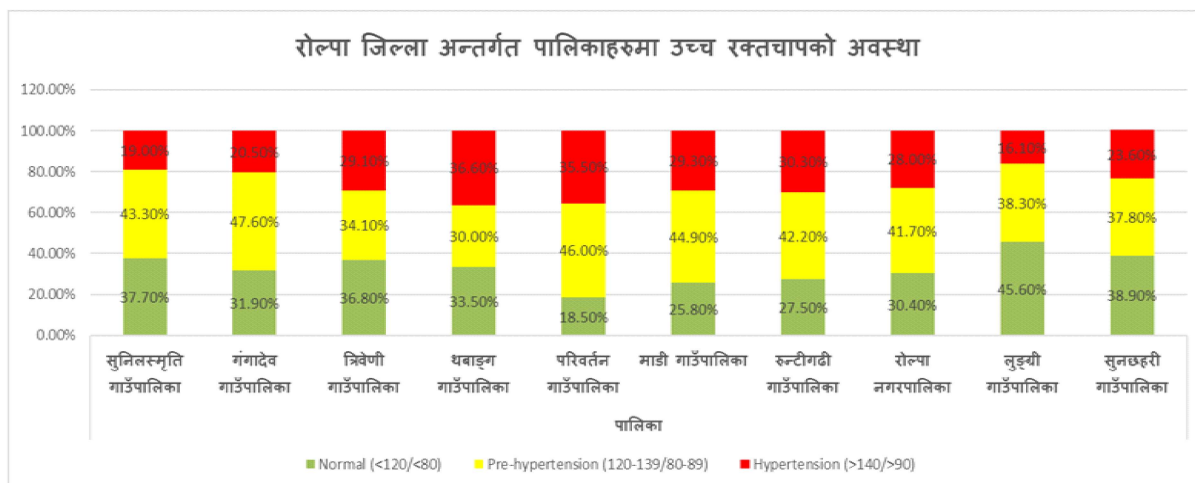
Source: Data received vertically from LLG

**3.8.4.11 Palika-wise distribution of hypertension, diabetes, and proteinuria in FY 2081/82 in Rolpa district under the “NCD screening program” of Lumbini Province**

**a. Prevalence of Hypertension in Rolpa District**

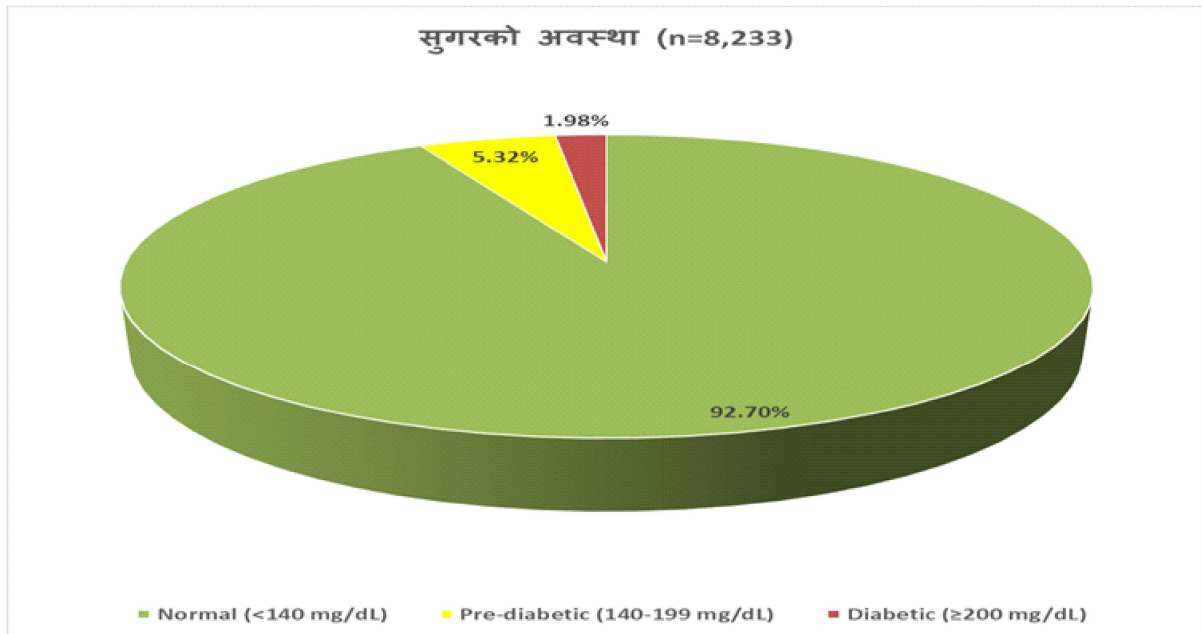


The prevalence of hypertension (>140/90) among 8233 in >30 years aged people, under the NCD screening program of Lumbini Province, was 26.44%. Similarly, 33.06% were pre-hypertension, and 40.50% of them were normal.

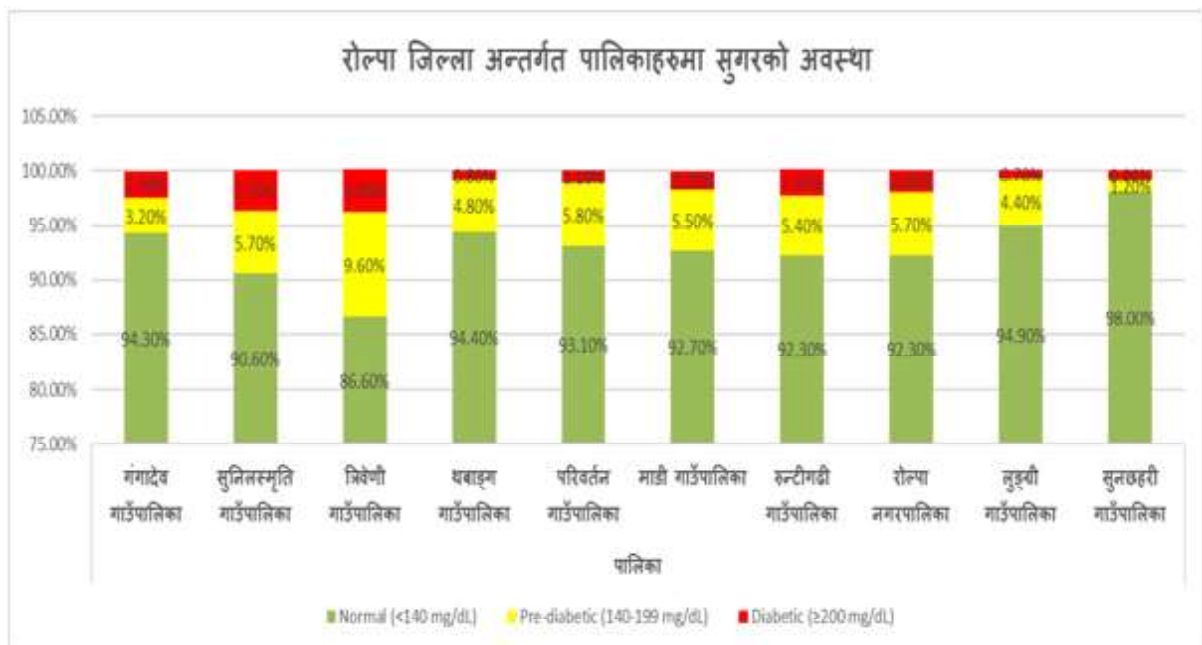


The prevalence of hypertension (>140/90) among 8233 in >30 years people, under the NCD screening program of Lumbini Province, was highest in Paribartan Rural Municipality (35.50%) and lowest in Lungri Rural Municipality (15.10%).

**b. Prevalence of Diabetes in Rolpa**

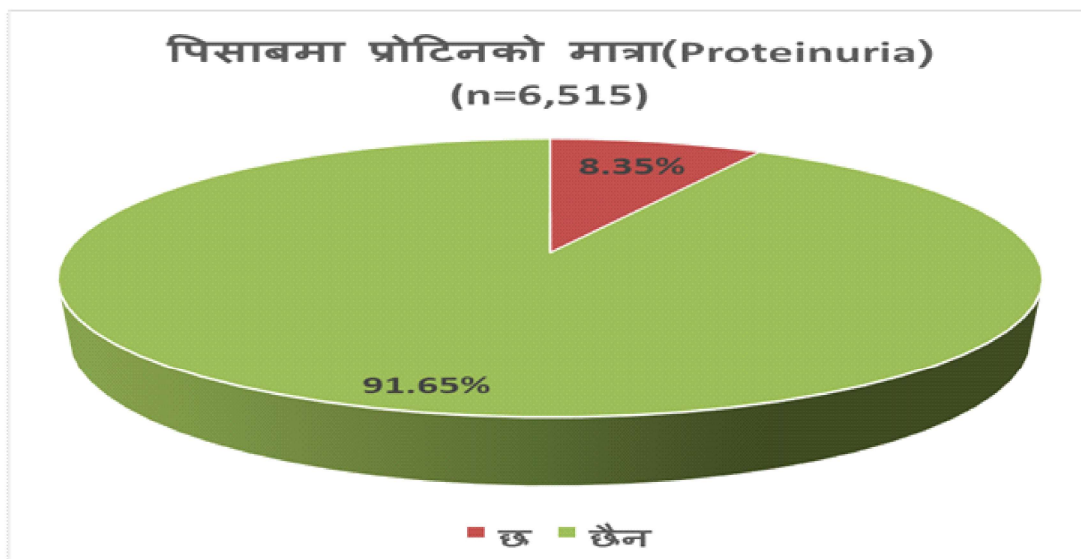


The prevalence of diabetes ( $\geq 200$  mg/dL) among 8233 in  $>30$  years aged people using random blood sugar test, under the NCD screening program of Lumbini Province, was 1.98%. Similarly, 5.32% were pre-diabetic, and 92.70% of them were normal.

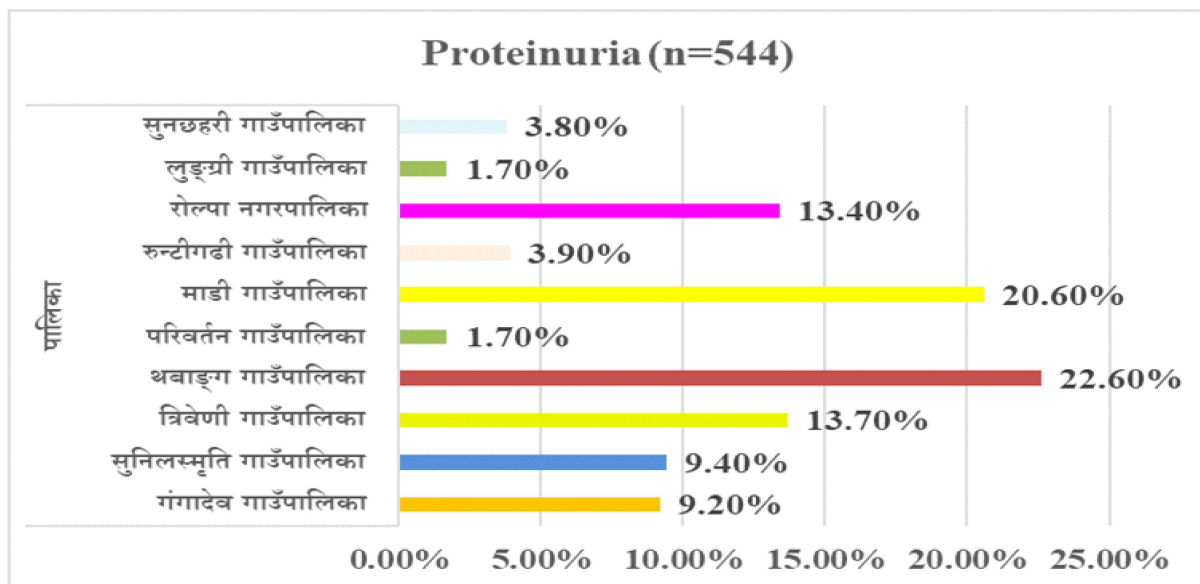


The prevalence of diabetes (>200 mg/dL) among 8233 in >30 years aged people using random blood sugar test, under the NCD screening program of Lumbini Province, was highest in Tribeni Rural Municipality (3.90%) and lowest in Lungri Rural Municipality (0.70%).

**c. Prevalence of Proteinuria in Rolpa**



The prevalence of proteinuria among 6515 in >30 years aged people using dipstick proteinuria range under the NCD screening program of Lumbini Province, was 8.35%.



The prevalence of proteinuria among 6515 in >30 years aged people using the dipstick proteinuria range under the NCD screening program of Lumbini Province, was highest in Thabang Rural Municipality (3.90%) and lowest in Lungri Rural Municipality (1.70%).

### 3.8.5 Major activities in FY 2081/82

- Implementation of **WHO-PEN (Package of Essential Non-communicable Disease Interventions)** at health facilities for early detection and management of common NCDs (hypertension, diabetes, COPD, etc.).
- Conducting **NCD screening camps** and routine screening for adults (blood pressure, blood sugar, BMI) at health facilities and outreach clinics.
- **Capacity building and training** of health workers on NCD prevention, diagnosis, treatment, and referral, including the use of PEN protocols.
- **Monitoring and supervision** of NCD service delivery at health posts, primary health care centers, and hospitals.
- **Coordination and partnership** with municipalities, NGOs, and the private sector for NCD prevention and control activities.
- **Data recording and reporting** on NCD cases through the Health Management Information System (HMIS) and routine program reviews
- **Procurement and distribution** of essential NCD medicines, supplies, and equipment (e.g., glucometers, BP machines, weighing scales).

### 3.8.6 Issues, Recommendations, and Responsibilities:

Issues/Challenges	Recommendations	Responsibilities
1. Limited awareness and health education on NCD risk factors in the community	Strengthen community-based awareness campaigns and school health programs focusing on lifestyle modification (diet, physical activity, tobacco/alcohol control).	HF, LLG
2. Shortage of trained human resources for NCD management	Provide regular training on NCD prevention, diagnosis, and case management for health workers at the local level.	PHTC, PHD, HO
3. Insufficient availability of essential medicines and diagnostic equipment	Ensure timely procurement and supply of NCD drugs and equipment (BP apparatus, glucometers, ECG machines) at health posts and hospitals.	PHD, HO, LLG
4. Limited financial resources for NCD activities	Advocate for increased budget allocation for NCD prevention and management at the local and district levels.	PHD, LLG, EDPs

## 3.9 Mental Health Program

### 3.9.1 Introduction

The history of mental health (MH) services in Nepal dates back to 2018 BS (1961 AD) when outpatient mental health services were introduced at Bir Hospital. Mental health disorders account for 18% of the total NCDs and are the fourth leading cause of disability in the country. According to the National Mental Health Survey 2077 (2020), 10% of the adult population experienced a mental disorder at some point in their lifetime, and 4.3% were living with a mental disorder at the time of the survey. Suicidality was found to be a significant concern, with 7.2% of individuals reporting suicidality, 6.5% experiencing current suicidality, 1.1% having attempted suicide in their lifetime, and 0.3% identified at risk for future attempts.

Vulnerable groups such as the poor, hard-to-reach populations, homeless individuals, those affected by conflict, survivors of violence, minority groups, non-binary gender populations, prisoners, and individuals in humanitarian settings face heightened risks for mental health disorders. Social stigma exacerbates the problem, as individuals with mental health conditions are often labeled as “crazy” and treated as sources of embarrassment.

In response to these challenges, the Government of Nepal has progressively strengthened its commitment to mental health. This includes establishing the NCDs and MH section and integrating mental health care as an essential service under the Public Health Services Act, 2075. Mental health services are now incorporated into the Basic Health Service (BHS) and Essential Health Service (EHS) Packages, as outlined in the Public Health Service Regulation. The National Health Policy of 2019, in section 6.17.5, sets forth a strategy to expand and integrate mental health services into the broader health system. Moreover, Nepal’s endorsement of the National Mental Health Strategy and Action Plan (NMHSAP) 2077 provides a comprehensive framework for planning and delivering mental health services.

DoHS has been implementing the WHO Special Initiative for workers and gatekeepers. The adaptation of the WHO’s for Mental Health with a program to catalyze the implementation of the National MH Strategy and Action Plan. The initiative at the global level seeks to ensure universal health coverage involving access to quality and affordable care for mental health conditions. The initiative has targeted two strategic actions: advance policies, advocacy, and human rights; and scale-up quality interventions and services for people with mental health conditions. Nepal is one of seven countries implementing WHO SIMH. This has enabled a timely and long-term opportunity for Nepal’s mental health system to go beyond small-scale project work and offers the MoHP a chance to build significant reform.

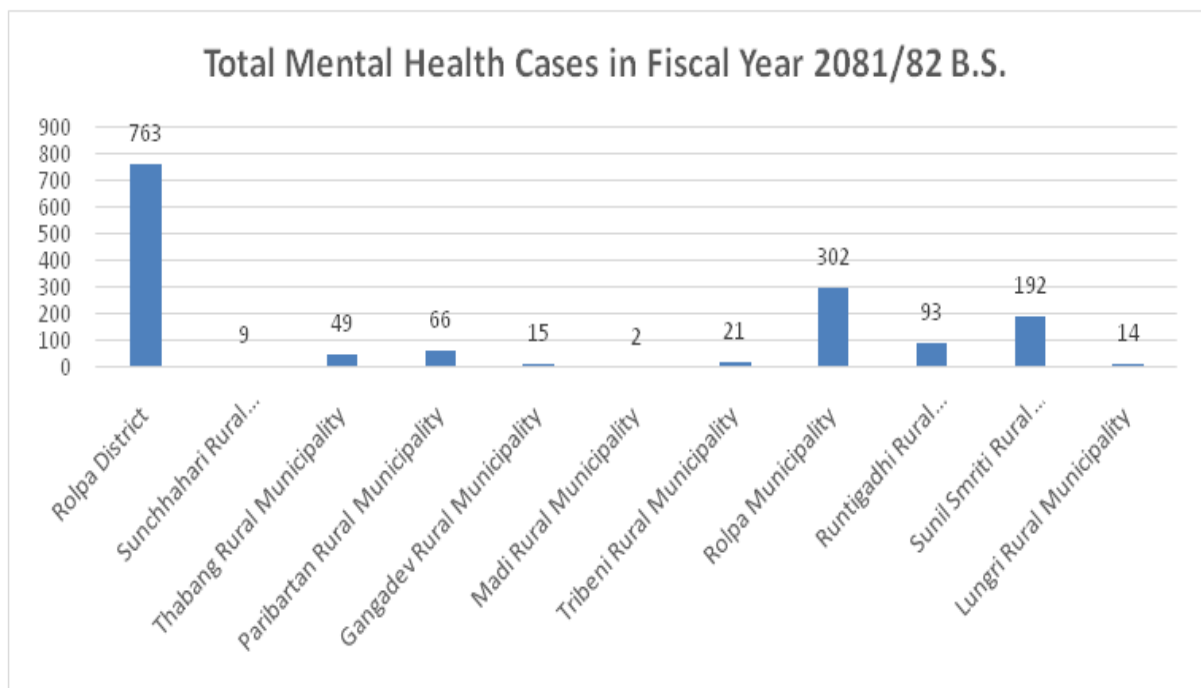
### 3.9.2 Indicators

#### 3.9.2.1 Three-year trend of major Indicators of mental health services in Rolpa district

Indicators	Fiscal Year		
	2079/80	2080/81	2081/82
Total number of mental health cases	150	469	763
Total number of mental health cases on treatment	140	419	691
Number of cases for Depression	20	66	135
Number of cases of anxiety disorder	5	35	4
Number of cases for Conversion disorder	0	23	3
Number of cases for Acute psychosis	0	1	6

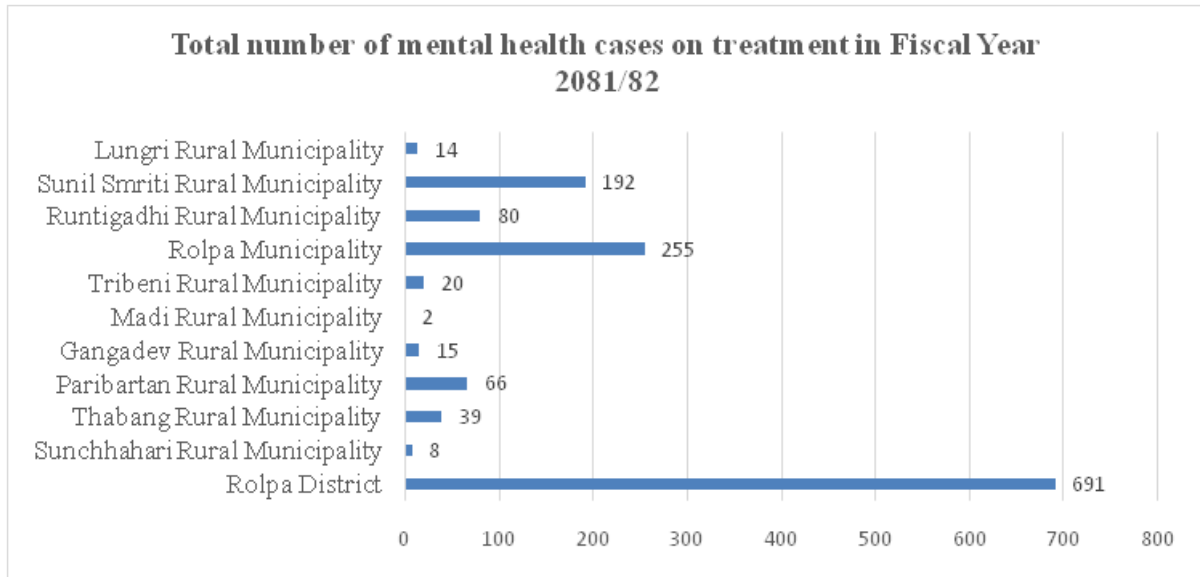
The total number of mental health cases has an increasing trend since three fiscal years. With 763 mental health cases in Fiscal year 2081/82 B.S., 691 of the mental health cases were on treatment.

#### 3.8.2.2 Palika-wise distribution of total mental health cases in Rolpa district



There were 763 mental health cases in the Rolpa district in fiscal year 2081/82 B.S. The highest number of mental health cases was from Rolpa Municipality (302 mental health cases), and the lowest number of mental health cases was from Madi Rural Municipality (2 mental health cases).

### 3.8.2.2 Palika-wise distribution of total mental health cases on treatment in Rolpa district



The total number of mental health cases that were on treatment in Rolpa district in fiscal year 2081/82 B.S. is 691. The highest number of mental health cases that were on treatment were from Rolpa Municipality (255), and the lowest number of mental health cases that were on treatment were from Madi Rural Municipality (2).

### 3.9.3 Major activities in FY 2081/82

- Provided ongoing clinical supervision and support to primary health care providers (including nurses and general health workers) on mental health care, counseling, and psychosocial support.
- Coordinated multi-sectoral collaboration and resource mobilization with governmental and non-governmental sectors for comprehensive mental health services.
- Maintained patient registers and monitored service delivery and medication stock at district health facilities.
- Provide referral and follow-up mechanisms to specialist mental health services through health institutions for complex cases.
- Facilitate advocacy and policy development for improved mental health legislation and services at the district level.

### 3.9.4 Issues, Recommendations, and Responsibilities:

Issues/Challenges	Recommendations	Responsibilities
Poor recording and reporting	Priority for recording and reporting related to Mental Health	HF's, LLG
Lack of training in Mental health among service providers and counselors	Provide training to paramedics and nurses regarding mental health.	NHTC/HTC/MOH/HD

## 3.10 Drinking Water Quality Surveillance Program

### 3.10.1 Introduction

The provision of safe and wholesome water is the constitutional right of every citizen. Safe drinking water, sanitation, and hygiene are crucial to human health and well-being. Safe WASH is not only a prerequisite to health, but contributes to livelihoods, school attendance, and dignity, and helps to create resilient communities living in healthy environments. Unsafe drinking water impairs health through illnesses such as diarrhea, and untreated excreta contaminates ground waters and surface waters used for drinking water, irrigation, bathing, and household purposes.

Chemical contamination of water continues to pose a health burden, whether natural in origin, such as arsenic and fluoride, or anthropogenic, such as nitrate. Safe and sufficient WASH plays a key role in preventing numerous NTDs such as trachoma, soil-transmitted helminths, and schistosomiasis. Diarrhoeal deaths as a result of inadequate WASH were reduced by half during the Millennium Development Goal (MDG) period (2000–2015), with the significant progress on water and sanitation provision playing a key role.

Evidence suggests that improving service levels towards safely managed drinking-water or sanitation, such as regulated piped water or connections to sewers with wastewater treatment, can dramatically improve health by reducing diarrhoeal disease deaths.

The revised National Drinking Water Quality Surveillance Guideline 2076 B.S. envisages surveillance of drinking water quality at central, provincial, and local levels through the Ministry of Health and Population and underlying institutions. EDCCD, being the secretariat of the National Drinking Water Quality Surveillance Committee, conducts drinking water quality surveillance-related activities through this section at the central level.

At the District level, drinking water quality surveillance is performed by HO to ensure the quality of drinking water and advocate for improvements.

### 3.10.2 Indicators

#### 3.10.2.1 Palika-wise distribution of laboratory for water quality test in FY 2081/82 in Rolpa district

S.N.	Local Level Name	Laboratory Locations	No. of Lab Sites
1	Rolpa Municipality	Rolpa Hospital/Health Office/Rolpa Municipality	2
2	Madi Rural Municipality	WASH Section	1
<b>Total</b>			<b>3</b>

There are three laboratory locations for water quality tests, two in Rolpa municipality and one in Madi Rural Municipality in Rolpa district in fiscal year 2081/82 B.S.

#### 3.10.2.2 Palika-wise distribution of water quality test in FY 2081/82 in Rolpa district

Local Level Name	Total tested sample	Test Results (E. coli)		Percentage of e.coli positive
		Positive	Negative	
Sunchhahari RM	20	15	5	75
Thabang RM	20	9	11	45
Paribartan RM	20	16	4	80
Gangadev RM	20	17	3	85
Madi RM	20	15	5	75
Tribeni RM	20	15	5	75
Rolpa Municipality	20	15	5	75.5
Runtigadhi RM	20	16	4	80
Sunil Smriti RM	20	13	7	65
Lungri RM	20	15	5	75
<b>Rolpa District</b>	<b>200</b>	<b>146</b>	<b>54</b>	<b>73%</b>

The percentage of E.coli positive among the total sample tested was 73% in Rolpa district in fiscal year 2081/82 B.S., with the highest percentage of e.coli in Gangadev Rural Municipality (85%).

### 3.10.3 Major activities in FY 2081/82

In FY 2081/82, HO Rolpa performed different activities like stakeholder meetings, water quality tests, and sharing the results through local media, etc. Water quality test performed at 200 different locations representing all local levels. Got the result that 73% of water had e.coli which is the major organism for water contamination. HO Rolpa has planned to advocate and build commitment via the district disaster management committee meeting and facilitate to formation of the local level water quality surveillance committee, implementation of the water safety plan, and make water quality surveillance effective and sustainable throughout the district.

### 3.10.4 Issues, Recommendations, and Responsibilities:

Issues/Challenges	Recommendations	Responsibilities
1. Health illiteracy among the public regarding safe drinking water	Implement community-based, culturally appropriate health education programs engaging FCHVs, local leaders, schools, and media to promote safe water practices and awareness of waterborne diseases.	HF's, LLG
2. Lack of budget for orientation to the water quality surveillance committee for the preparation of the water safety plan and its monitoring	Advocate for dedicated funding and collaboration with partners to build capacity through cost-effective, integrated water safety plan training, while documenting benefits to strengthen political and financial support.	LLG, HO, PHD, GoN, EDPs

## **CURATIVE SERVICES**

### **4.1 Introduction**

Curative services are medical treatments with the intent to cure a disease, promote recovery, or eliminate an injury. These services focus on overcoming illness rather than just managing symptoms or providing comfort.

Article 35 of Nepal’s Constitution (2072) guarantees every citizen the right to free basic and emergency health services. This right is upheld through an extensive network of health facilities, including health posts, PHCCs, urban health promotion centers, and community units, focusing on nutrition, family planning, immunization, maternal and child health, and disease prevention. The Public Health Service Act (2075) and Regulation (2077) further define Basic Health Services (BHS) as comprehensive and inclusive, outlining nine essential elements: vaccination, IMNCI, nutrition, MNCH (including family planning and reproductive health), infectious disease control, mental health, geriatric care, emergency services, health promotion, and traditional medicine. These are subdivided into 42 categories to ensure holistic health coverage for all citizens.

### **Basic health service delivery units at the three levels of government**

<b>Local level</b>	<b>Province level</b>	<b>Federal level</b>
<ul style="list-style-type: none"> <li>➤ Basic hospital (5, 10, 15 beds)</li> <li>➤ Basic Health Service Centers (BHSCs)</li> <li>➤ Primary Health Care Centers (PHCC)</li> <li>➤ Health Posts (HP)</li> <li>➤ Community Health Unit (CHU)</li> <li>➤ Urban Health Center (UHC)</li> <li>➤ Ayurveda Dispensaries (Aushadhalaya)</li> </ul>	<ul style="list-style-type: none"> <li>➤ General Hospital (25-200 beds)</li> <li>➤ Provincial Ayurveda Hospital</li> <li>➤ Provincial Ayurveda Chikitsalaya /Ayurveda Health Center</li> </ul>	<ul style="list-style-type: none"> <li>➤ General Hospital (200 plus beds)</li> <li>➤ Specialized and Super Specialized Hospitals</li> <li>➤ Teaching Hospital (Academy and others)</li> <li>➤ Central Ayurveda Hospital</li> </ul>

## 4.2 Curative services in Rolpa district

Curative services in Rolpa district are provided by Rolpa hospital, which is 50-bedded hospital located in Reugha, ward number two in Rolpa Municipality, which provides comprehensive curative health services like outpatient, inpatient, emergency, maternal and obstetric care, surgical, diagnostic, dental, physiotherapy, pharmacy, ophthalmology, and specialized programs like DOTS. Similarly, there is a Thabang basic hospital in Thabang Rural Municipality and two Primary Health Care Centers named as Sulichour PHC in Sunilsmriti Rural Municipality and Holeri PHC in Runtigadhi Municipality, comprising medical officers. Likewise, there are Basic Health Service Centers, Health Posts, Urban Health Centers, and Community Health Units in ten local levels under the Rolpa district providing curative services as per the Public Health Service Act (2075) and Regulation (2077).

## 4.3 Indicators

### 4.3.1 Three-year trend of major curative services (modern medicine) in Rolpa district

Indicators	Fiscal Year		
	2079/80	2080/81	2081/82
% of population utilizing emergency services at hospitals	3.27	2.73	2.66
Total Emergency patients who underwent minor surgeries	228	215	159
Total inpatients who underwent minor surgeries	14	45	22
Total outpatients who underwent minor surgeries	73	59	59

The percentage of population utilizing emergency services and total emergency patients undergoing minor surgeries is in a decreasing trend since the last three fiscal years and was 2.66 and 159 in fiscal year 2081/82, respectively.

### 4.3.2 Three-year trend of curative services (alternative medicine) in Rolpa district

Apart from modern medicines provided by Hospitals, PHCCs, Basic Health Service Centers, Health Posts, Urban Health Centers, and Community Health Units, there are also Ayurvedic institutions providing alternative medicine. There is one ayurvedic health center (ayurvedic chikitsalaya) in Rolpa municipality, two ayurvedic dispensaries (ayurvedic aushadhalaya), one each in Madi Rural Municipality and Sunil Smriti Rural Municipality, and four citizens' health centers (nagarikarogyakendra), one each in Gangadev, Thabang, Lungri, and Tribeni Rural Municipalities.

## Health Office, Rolpa

Indicators	Fiscal Year		
	2079/80	2080/81	2081/82
Inpatient Services (Number of Patients)	0	0	0
Outpatient Services (Number of Patients)	13069	16462	16553
Senior Citizen Services	1215	1665	1639
Purvakarma / Panchakarma Services	955	1066	904
Sthanpai	448	893	901
Total Patients at Health Camp	217	0	0
Surgical Services (Ksharsutra etc.).	0	0	0
<b>Total</b>	15903	20086	20801

The total number of people served from alternative medicine was in an increasing trend since the last three fiscal years and was 20801 in Rolpa district in fiscal year 2081/82 B.S.

### Number of people receiving diagnostic services annually (FY 2081/82):

S.N.	Health Service	Total number of patients
1	Hematology	374
2	Biochemistry	601
3	Others	155
	<b>Total</b>	<b>1130</b>

The total number of people receiving diagnostic services from alternative medicine was 1130 in the Rolpa district in the fiscal year 2081/82 B.S.

### 4.3.3 Palika-wise distribution of the number of senior citizens treated in FY 2081/82 in Rolpa district under the “senior and disabled citizens home visit program” of Lumbini Province

Name of LLG	Number of senior citizens above 80 years treated		
	Female	Male	Total
Thabang Rural Municipality	132	134	266
Runtigadhi Rural Municipality	95	136	231
Rolpa Municipality	206	180	386
Pariwartan Rural Municipality	191	146	337
Madi Rural Municipality	127	140	267
Tribeni Rural Municipality	118	158	276
Sunil Smriti Rural Municipality	283	302	585
Sunchhari Rural Municipality	187	149	336
Lungri Rural Municipality	174	232	406
Gangadev Rural Municipality	105	122	227
<b>Rolpa District</b>	<b>1688</b>	<b>1699</b>	<b>3317</b>

The number of senior citizens above 80 years treated under the “senior and disabled citizens home visit program” of Lumbini Province was 3317 in Rolpa district in fiscal year 2081/82 B.S., with the highest number in Sunil Smriti Rural Municipality (585) and the lowest number in Gangadev Rural Municipality (227).

#### **4.4 Major Activities carried out during the FY 2081/82**

The major activities conducted by health institutions under the health office, Rolpa, in Rolpa district are:

- Outpatient services for general illnesses and minor ailments
- Maternal, newborn, and child health (MNCH) services, including antenatal, delivery, and postnatal care
- Family planning and reproductive health services
- Immunization services (EPI program)
- Nutrition assessment, counseling, and supplementation
- Integrated Management of Newborn and Childhood Illness (IMNCI)
- Communicable disease control programs (e.g., TB/DOts, malaria, leprosy)
- Non-communicable disease (NCD) screening and management
- Health education and health promotion activities
- Environmental health and sanitation promotion
- Minor emergency and first aid services
- Referral services to higher-level health facilities
- Community outreach and mobile clinics
- School and community health programs
- Alternative health services

#### **4.5 Issues, Recommendations, and Responsibilities**

<b>Issues/Challenges</b>	<b>Recommendations</b>	<b>Responsibilities</b>
Inadequate availability of essential drugs and equipment	Ensure timely procurement and distribution of drugs, instruments, and logistics	LLG, HO, PHD
Irregular service delivery due to absenteeism	Strengthen supervision and monitoring; enforce attendance and accountability mechanisms.	HF in-charge, LLG
Limited diagnostic and laboratory services	Upgrade diagnostic facilities and ensure functional equipment	LLG, HO, PHD
Weak referral system	Develop and implement an effective referral protocol with proper documentation.	Health Workers / PHCC In-Charge

## SUPPORTING PROGRAM

### 5.1 Female Community Health Volunteer Program

#### 5.1.1 Introduction

The Female Community Health Volunteer (FCHV) program was established in 1988 and is a vital component of the nation's community-based healthcare system. The primary goal of the program was to improve the quality and accessibility of primary healthcare services, especially for women and children. By 2050 B.S., the program had spread to all 77 districts after being introduced in 27 at first. It had changed from a ward-based strategy to a population-based model in 28 districts. The program's objectives are to empower women via education and skills, raise public health awareness, and involve local institutions in healthcare promotion in order to promote community health.

FCHVs are chosen by mothers' groups and are essential in basic healthcare services, illness prevention, and health promotion. Initially, FCHVs used to receive 18 days (9 + 9 days) of training; however, from FY 2077/78, the training has been revised to 10 days of basic training and 4 days of refresher training every four years. Following the training, to help them perform their duties, they are given essential resources such as medicine kit boxes, manuals, flipcharts, ward registers, Information Education and Communication (IEC) materials, FCHV bags, signboards, and identity cards. In addition, they are provided with necessary supplies such as family planning commodities like pills and condoms, iron tablets, vitamin A capsules, and Oral Rehydration Solution (ORS) via health facilities.

Important public health milestones, including lower rates of maternal and infant mortality and the advancement of Millennium Development Goals (MDGs) 4 and 5, have been made possible significantly due to FCHVs' efforts. Likewise, FCHVs who are acknowledged as important contributors to community health are anticipated to contribute significantly to the attainment of Sustainable Development Goals (SDGs) by 2030. The latest amendment of the FCHV strategy 2076 B.S., such as changes in FCHVs' selection criteria and institutional arrangement, highlights the government's dedication to strengthening the FCHV program.

There are currently about 50,396 FCHVs actively serving in health care in Nepal. The crucial role FCHVs play in providing community healthcare is highlighted by these statistics, which show minor regional variations that reflect the dynamics of volunteer engagement in different provinces.

### **5.1.2 Goal and Objectives**

**Goal:** Improve the health of the local community by promoting public health. This includes imparting knowledge and skills for empowering women, children, and others, increasing awareness of health-related issues, and involving local institutions in promoting health care.

#### **Objectives**

- Mobilize a pool of motivated volunteers to connect health programs with communities and to provide community-based health services.
- Activate women to tackle common health problems by imparting relevant knowledge and skills.
- Increase community participation in improving health,
- Develop FCHVs as health motivators and
- Increase the demand for health care services among community members.

### **5.1.3 FCHV's contributions in health service delivery**

1. Distribution of the FP commodities (refill regular pills, emergency contraception pills, and distribute condoms).
2. Conducting the mother's health group meetings, discussing issues, and providing health education.
3. FCHVs support mothers and newborns' care during home visits in the postnatal period (in the first week of delivery) to provide care and health counseling to postpartum mothers on breastfeeding, care of mother and newborn, as well as danger signs of mother and newborn, and encourage them to attend postpartum visits to institutions as per the national protocol. They also provide support to postpartum mothers in initiating breastfeeding within 1 hour of birth and immediately provide a Vitamin A capsule as well.
4. FCHVs also play a crucial role in reducing malnutrition among children and women of reproductive age groups.
5. FCHVs assess the acute malnutrition status of children under 5 years of age by measuring the Mid-Upper Arm Circumference (MUAC) of children and then referring them for further management as per their severity.

### 5.1.4 Facilities for FCHV

- A total of NPR. 10,000/- is provided to each FCHV as a dress allowance every year.
- A travel allowance of NPR. 12,000/- is provided to each FCHV as transportation cost every year
- Since 2071/72 B.S., the government has allocated a budget of NPR 20,000/- to each FCHV as an appreciation for their contribution during the farewell to FCHV over 60 years of age, as recommended by health mothers' groups. In addition to this, the Lumbini Province Government started to felicitate with Rs 50,000 at the time of retirement, over 60 years of age.
- International Volunteer Day (5<sup>th</sup> December) is celebrated as Female Volunteer Day every year.
- The Government of Nepal bears 50% of the premium of health insurance for individual FCHV, and they are one of the target groups to receive service through the Social Service Unit of Health Facilities.
- Local and provincial level provides a top-up to up above-mentioned budget heading.

### 5.1.5 Indicators

#### 5.1.5.1 Major Indicators of the FCHV Program

Indicators	Fiscal Year		
	2079/80	2080/81	2081/82
No. of FCHVs	459	459	459
% of FCHVs Reporting	98.8	99.46	99.67
Health Mother's group meeting held (%)	97.56	99.09	99.54
Average no. of people served by FCHV per month	26.31	26.15	25.34

The reporting percentage of FCHVs has increased since the last fiscal year and was 99.67% in fiscal year 2081/82 B.S. Similarly, the number of health mothers' group meetings held by FCHVs has increased since the last fiscal year and was 99.54% in fiscal year 2081/82 B.S. But the average number of people served by FCHV per month has decreased since the last three fiscal years and was 25.34% in fiscal year 2081/82 B.S.

### 5.1.5.2 FCHVs' Key Service Delivery Indicators

Services	Fiscal Year		
	2079/80	2080/81	2081/82
Pills distribution	4700	3648	3141
Condom distribution (pieces)	89914	73163	74753
Iron tablet distribution	2355	1517	641
Support in initiating breastfeeding within an hour of birth	123	85	33
Chlorhexidine applied to the cord	93	86	31
% of postpartum mothers who received a vitamin A supplement	98.83	98.64	104.50
% of pregnant women visited by FCHVs	176.89	199.06	217.36
% of postpartum women visited by FCHVs	7.87	4.5	3.45
% of children aged 6-59 months screened for malnutrition by FCHV	165.57	238.56	281.21

The percentage of pregnant women visited by FCHVs has increased since the last three fiscal years and was 217.36% in fiscal year 2081/82, but the percentage of postpartum women visited by FCHVs has decreased since the last three fiscal years and was 3.45% in fiscal year 2081/82 B.S. The number of pills and iron tablets distributed by FCHVs has also decreased since the last three fiscal years, and was 3141 and 641, respectively, in fiscal year 2081/82 B.S.

### 5.1.6 Major Activities carried out during the FY 2081/82

- Biannual review meeting of the FCHV program
- FCHV day was celebrated on 5<sup>th</sup> December with a FCHV felicitation program for the best performing FCHVs
- Basic and Refresher training for FCHVs
- Distribution of dress allowance for FCHVs, i.e., Rs. 10000 per FCHV
- Farewell Program for aging and low-educational FCHVs, and replaced by educated FCHVs
- FCHV ID card distribution to newly recruited FCHVs
- Mobilization of FCHVs to COVID-19 and other public health movements
- Nutrition services provided by FCHVs at the household level
- Orientation and mobilization of FCHVs for national health programs, including mobile health programs

### 5.1.7 Issues, Recommendations, and Responsibilities

<b>Issues/Challenges</b>	<b>Recommendations</b>	<b>Responsibilities</b>
Aging and low educational status of FCHVs.	Need to appoint of educated female FCHV and establish the proper exit policy of FCHVs.	R/M, NSSD
Poor recording and reporting status of the FCHV register	Assist needy FCHVs in proper recording and reporting by health workers	HO, HF, R/M
Many new FCHVs are recruited without basic training	Provision of basic training to newly recruited FCHVs	HO, MoH, NSSD
Low utilization of the FCHV fund	Strictly implement the guidelines and audit the FCHV fund every year	R/M
Decreasing work performance of FCHV	Motivate FCHV through the FCHV review meeting and orientation for the FCHV on the related program.	NSSD, HO, HFs, LLG
The FCHV allowance is very low	Need to upgrade the FCHV allowance according to the other health workers	MoH, LLG
Poor performance in IT	Need to be oriented in IT (Mobile application)	MoH, HO, LLG

## 5.2 National Health Training Center

### 5.2.1 Introduction

A competent, motivated, healthy workforce forms the core of a high-quality, effective, and efficient health system. In line with the national policies, plans, and programs of the Ministry of Health and Population (MOHP), the National Health Training Center (NHTC), established in 2050 BS, runs as a federal body for coordination and management of all health training in Nepal. It is primarily responsible for policy formulation, planning/budgeting, need assessment, curriculum design, implementation, monitoring and evaluation (M&E), follow up and overall quality assurance related to the training system. It is also responsible for accrediting clinical training sites and Clinical and public health-related training courses to maintain the standard of health training so as to strengthen the capacity of health service providers across the country. The training network includes seven provincial health training centers and 66 clinical training sites. The key guiding document for NHTC is the National Health Training Strategy 2060/61 (2004).

### 5.2.2 Vision, Goal, and Objectives of NHTC

**Vision:** An Effective health training system for the development of a skilled and accountable health workforce to provide quality health services.

**Goal:** To enhance the technical and managerial capacity of health care service providers at all levels to deliver quality health care services towards the attainment of the optimum level of health status of Nepali citizens.

**Objectives:**

1. To standardize the training Learning Resource Packages (LRP) of different trainings
2. To organize and conduct in-service training to address the needs of the country and to support the quality of care by enhancing the service providers' competency.
3. To ensure the quality of training activities by different mechanisms in adherence to national standards, and to enhance the capacity of different training sites.
4. To adopt and promote innovative training approaches
5. To strengthen the mechanism and capacity for post-training follow-up, enhancement, and support

**Strategies of NHTC for Capacity Building of HR**

1. Assessing, standardizing, and accrediting training sites
2. Development, standardization, and revision of training
3. Institutional capacity development of all levels of training sites
4. Conduct pre-service, in-service, short-term, and long-term training as per national requirements

5. Integration and institutionalization of training activities
6. Developing links with professional career development
7. Strengthening TIMS and developing the trainer's roster at all levels
8. Interaction with academic health institutions regarding the integration of training materials into the regular academic programs
9. Training material development and field test of the new training
10. Revise/update and publicize training materials as required and demanded by the centers and the program divisions, and the development partners
11. Health Training Need Identification (along with local and provincial levels)

### **5.2.3 Major Training Activities carried out in FY 2080/81 in Rolpa District**

Training is a way of helping people to do things that they could not do before they were trained. Training is a cross-cutting support program to contribute to effective health services delivery in the country with its optimal level of quality of training. Training is an important tool for human resources for skill development. District-level training Programs are conducted based on the program perspective as set by the National Policy & Programs. HO, Rolpa conducted several trainings like HMIS/DHIS-2, eLMIS, Immunization, TB modular, Clinical update, PEN, Mental Health, Basic Immunization, TB modular, FCHV Basic/refresher Training, and PMTCT to health workers, etc. The training programs in the district are conducted under regular programs of MOHP/DOHS/MoH/HD/HTC, and with the support of non-government partners to support and strengthen the district programs and enhance performance.

#### **Major Training Activities carried out in FY 2081/82**

- Training needs assessment
- HMIS training for newly recruited health workers
- eLMIS Rollout Training
- DHIS-2 Training for all health coordinators and health facility-level staff
- Maternal and Neonatal Health (MNH) update training to nursing staff
- School health and ASRH training to School teachers and HF in charge
- Basic/Refresher Training to FCHV
- CB-PMTCT Training
- IMNCI Training
- Basic TB Modular Training
- PEN training

- Basic Immunization and AEFI management training to health workers
- MIYCF Training and orientation to health workers and FCHVs
- Basic ENT Training/ Orientation
- Selection for A/SBA, Implant/IUCD, MLP, Medical abortion, Medicolegal, Minilap, NSV, Infection Prevention training, etc., and conducted with the leadership of HTC
- Mobile Health Training to Health Workers and FCHV
- IPC training for the nursing staff and office assistants
- IPC and sanitation orientation to the FCHV
- VCAT training for nurses

**5.2.4 Issues, Recommendations, and Responsibilities in Human Resource Training by Health Office:**

<b>Issues/Challenges</b>	<b>Recommendations</b>	<b>Responsibilities</b>
Lack of training needs assessment before planning sessions	Carry out periodic Training Needs Assessments (TNA) to identify gaps and prioritize training areas.	PHTC, HO, LLG
Unequal training opportunities leading to skill gaps among staff	Develop equitable training selection criteria, ensuring inclusion of staff from all health facilities and service levels.	HO, LLG, HF in-charge
Limited budget allocation for human resource development	Advocate for increased budget for training in the annual district health plan and mobilize support from development partners.	MoH, PHD, HO, LLG
High staff turnover and transfer after training	Coordinate with provincial and local authorities to ensure retention of trained staff in relevant positions.	MoH, PHD, LLG
Lack of post-training follow-up and performance monitoring	Implement post-training supervision and mentorship to assess skill application in the workplace.	HO

## 5.3 Health Education, Information, and Communication

### 5.3.1 Introduction

National Health Education Information and Communication Center (NHEICC), established in 2050 B.S. (1993), is the federal body for health promotion activities. It plans, implements, monitors, and evaluates diverse health promotion programs, including advocacy, health education, communication, community engagement, and research. Guided by the National Health Communication Policy 2069 (2012), National Health Policy 2076 (2019), and other relevant policies, NHEICC supports national health programs to address health policies and to achieve SDGs. Employing key approaches like advocacy, social mobilization, and SBCC, NHEICC has four sections, namely Health Promotion, Non-communicable Disease and Tobacco Regulation Section, Health Education and Material Development Section, Health Communication Coordination Section, and Administrative Section. Each of the sections of the center works in close coordination with the MoHP and DoHS-related divisions and centers for the needful SBC program tailoring based on the health promotion strategies of NHEICC. The NHEICC is the focal point of the Ministry of Health and Population (MoHP) for tobacco and alcohol control and regulation, along with Risk Communication and Community Engagement (RCCE).

### 5.3.2 Vision, goal, objectives, and strategies of NHEICC

**Vision:** Healthy, conscious, and responsive citizens concerned with a happy life

**Goal:** To promote health, prevention, and control of diseases, and increase the maximum utilization of available health care services

**Objective:** To promote the health of the people by raising health awareness and preventing diseases through the efforts of the people themselves and the full utilization of available health services

**Specific objectives:**

1. To assist the MOHP in formulating national acts, policies, strategies, and guidelines related to health promotion and health communication.
2. To regulate the marketing of alcohol and tobacco products, as well as harmful health products, in coordination with the relevant agencies.
3. To strengthen, expand, and implement health promotion programs and RCCE at all levels.
4. To facilitate related stakeholders to make healthy settings like “healthy palika”, health-promoting schools, health-promoting workplaces, health-promoting hospitals, etc., with the support and coordination of relevant stakeholders.
5. To generate, collect, and mobilize resources to implement health promotion and communication programs.
6. To develop and update Social and Behavior Change Communication (SBCC) materials in coordination with relevant stakeholders.

7. To provide technical support for health promotion, education, and material development at all levels.
8. To mobilize and use modern and traditional health education methods and media to increase health literacy and promote healthy behavior among the general public.
9. To prevent the inappropriate and unauthorized dissemination and duplication of messages or information and IEC materials on different health-related issues.

### Strategies

Health education, information, and communication activities are implemented by NHEICC based on health promotion strategies such as:

**1. Advocacy:** Advocacy communication will be conducted at all government levels to engage key stakeholders in supporting health promotion activities like NCD control, communicable disease prevention, healthy communities' formation, tobacco and alcohol regulation, adolescent health, family planning, maternal health, and implementing Risk Communication and Community Engagement guidelines.

**2. Social mobilization and community engagement:** Social mobilization and community engagement involve decentralizing health programs through local structures to enhance resource mobilization and service coverage, while also generating demand for health services via health mother groups, clubs, and other stakeholders.

**3. Mediate:** Health promotion requires coordinated efforts from all stakeholders, including government tiers, health and non-health sectors, NGOs, religious leaders, influencers, and the media, with the NHEICC playing a crucial role in mediating diverse interests to advance health promotion interventions.

**4. Social Behavior Change Communication (SBCC):** SBCC aims to promote positive individual behaviors, and it develops disability-friendly printed and electronic IEC materials incorporating the GESI principle to ensure equitable access to health education and information for all individuals.

**5. Digitalization in health promotion and communication:** The NHEICC utilizes digital technology to create platforms for health information and education, developing various web portals, digital communication systems, and infographics to enhance access to health resources for the public.

**6. Mass media approach:** The NHEICC utilizes various mass media, including television, radio, digital boards, and online and printed media, to disseminate health messages and information while also engaging in social listening through media monitoring.

**7. Policy, strategies, and directives formulation:** NHEICC formulates policy, strategies, and directives for the proper implementation of health promotion activities as per the need.

### 5.3.3 Major Health Education, Information, and Communication Activities carried out in FY 2081/82 in Rolpa District

- Public awareness program on non-communicable diseases at the community level
- Interaction program on FP, safe motherhood, and newborn care
- IEC/BCC material production/distribution, and publication in local magazines and papers
- Community-level interaction program and health promotion campaign
- Additional School health programs
- Production and airing of health radio programs and messages through local FM/radio and print media regarding different public health programs and activities
- Celebration of different health-related days/events
- Supervision and monitoring of IEC/BCC activities
- Establishment of well-managed IEC Corner health facilities representing all local levels in the district
- Conduction of COVID-19 and neglected tropical disease prevention-related awareness activities
- Home visit for counseling, psychosocial support, diagnosis, treatment, and referral services, and advocacy regarding health promotional activities towards 80+ years old people and differently able people throughout the district, and benefited around 3600 people around the year.
- Mobilize all the FM/radio and printed media within the district for advocacy and health promotional programs.

### 5.3.4 Issues, Recommendations, and Responsibilities of HEICC by HO:

Issues/Challenges	Recommendations	Responsibilities
Limited dissemination of health education and IEC materials to communities and health facilities	Strengthen distribution and ensure the timely availability of IEC/BCC materials in all health facilities and schools.	PHD, HO, LLG
Low community awareness and participation in health promotion activities	Conduct regular community mobilization, awareness campaigns, and social behavior change communication (SBCC) programs.	HO, LLGs, HFs, and FCHVs.
Lack of trained human resources in health communication	Provide orientation and training to health workers on effective health communication, interpersonal counseling, and message dissemination.	PHTC, HO, LLG

## 5.4 Health Management Information System

### 5.4.1 Introduction

The Health Management Information System (HMIS) operating on District Health Information System 2 (DHIS-2), an ICT-friendly platform with highly scalable features, manages health sector information in an integrated and comprehensive manner through a one-door system as recommended by the health policy, Public Health Act, Public Health Service Regulation, and cabinet decision. To reach its current state, HMIS has come through several significant milestones. Revision of the HMIS tool in FY 2078/79 was the largest effort in the history of tool revision by IHIMS. The tool revision was based on covering the additional health-related issues, such as mental health, health education information, etc. There are now 68 HMIS recording tools and 5 reporting tools, among which recording tools are completely paper-based, whereas reporting is directly done through online HMIS/DHIS2, which is maintained in paper-based reporting forms (tools) in HFs.

#### The following are the reporting forms used in HMIS:

- HMIS 9.1: Female Community Health Volunteer (FCHV),
- HMIS 9.2: PHCORC report,
- HMIS 9.3: Community health units (CHU), Urban Health centers (UHC), health posts (HP), and Primary Health Centers (PHC) report,
- HMIS 9.4: Public hospitals report and
- HMIS 9.5: Remaining non-public health facilities/organizations report

### 5.4.2 Vision, Mission, and Objectives of HMIS

**Vision:** Health Management Information System with the capacity to maintain continuous support for health sector planning and performance measurement at all levels

**Mission:** To provide timely, relevant, accurate, and complete information in a sustainable and integrated manner, by well-trained and highly motivated staff with the necessary resources and appropriate technology

#### Objectives:

1. Provide access to data/information to concerned authorities on time (NPC, Federal Ministry, Provincial Ministry, and local-level government)
2. Help to develop appropriate health policy and guidelines
3. Support for the Planning, Monitoring, and Evaluation (PME) management cycle of all health programs

4. To support the planning activities of all health programs.
5. To monitor the achievement, coverage, continuity, and quality of health services.
6. To help assess progress (evaluation) towards goals and targets of district health programs.

### 5.4.3 Mechanism of HMIS Reporting

HMIS reports are collected at the time of the monthly meeting in the district and discussed about the target versus achievement and decide future action for improvements of the programs.

- The monthly review and reporting meeting of the HFs at ten municipal-level centers (within the district) is organized on the 8<sup>th</sup> day of every month.
- A monthly review meeting is regularly organized at the district level on the 15<sup>th</sup> day of every month, which is a major innovation of the HO, Rolpa.
- The agendas of the meeting are program achievements, weaknesses, issues, challenges, and major innovations to accomplish the basic health services at the local level.
- Besides this, the agendas for the meeting are regularly provided by HO to LLG.

### 5.4.4 Status of HMIS Reporting in FY 2081/82

Name of LLG	Number of self-reporting health institutions in DHIS-2	Reporting rate	Reporting Rate on Time
Sunchhahari Rural Municipality	7	100	100
Thabang Rural Municipality	9	100	100
Paribartan Rural Municipality	9	100	100
Gangadev Rural Municipality	9	100	100
Madi Rural Municipality	10	100	100
Tribeni Rural Municipality	7	100	100
Rolpa Municipality	16	100	99.51
Runtigadhi Rural Municipality	12	100	97.73
Sunil Smriti Rural Municipality	10	100	100
Lungri Rural Municipality	9	100	100
<b>Rolpa District</b>	<b>98</b>	<b>100</b>	<b>99.82</b>

The reporting rate was cent percentage in the Rolpa district in fiscal year 2081/82 B.S., with 99.82% reporting rate on time.

### 5.4.5 Major HMIS Activities carried out in FY 2081/82 in Rolpa District

- Prepared, printed, and distributed the Annual Health Report
- HMIS and DHIS-2 training to local-level health workers to establish and improve the online reporting mechanism
- Monthly, Quarterly, and Annual performance review and data verification workshop at each municipal level, as well as the district level
- Prepare monthly meeting agendas for LLG
- On-site Coaching and Integrated/Supportive supervision
- Routine data quality audit and provide feedback on data quality among respective HF and LLG
- Revised HMIS training, distribution of HMIS tools to health facilities

### 5.4.6 Issues, Recommendations, and Responsibilities of HMIS by HO:

Issues/Challenges	Recommendations	Responsibilities
High workload for data entry and reporting	Assign dedicated data focal persons at major facilities and promote task-sharing.	LLGs and HF in-charge
Low motivation among staff for data-related tasks	Recognize good-performing facilities and staff through incentives or public acknowledgment.	HO, LLG
Poor data quality (inaccuracy, inconsistency, duplication)	Conduct periodic data quality assessments (DQA) and on-site data verification.	Focal person in HO, LLG, HF in-charge
Limited use of data for planning and decision-making	Promote data use workshops and integrate evidence-based planning at the district and local levels.	HO and Local Governments (Municipal Health Sections).

## 5.5 Logistic Management Information System

### 5.5.1 Introduction

The Nepal Constitution 2072 B.S. has provided that every Nepali citizen has the right to free basic health services from the state. The continuity in the logistics management for the uninterrupted supply of medicines, vaccines, and health commodities is inevitable for the assurance of the right to health of the citizens. Communicating the right information at the right time from top to bottom levels of the state is a prerequisite for this. Data-based information plays a vital role in developing strategy, forecasting, quantification, procurement planning, pipeline monitoring, storage, and distribution. If important information from local levels such as stock quantity, distribution numbers, expiry information, batch numbers, disposed commodities, excess stock levels and stock out can be included in the logistics management system, it will no doubt lead to prompt decision making at central, provincial as well as local levels and citizens will not be denied access to timely, efficient and continuous health services. In the context of increasing the quantity of the medicine under the free-of-cost program, an accurate and reliable data management system is essential for effective forecasting, quantification, and procurement or distribution system.

To streamline logistics management, the LMIS unit was established within the Logistics Management Division (LMD) in fiscal year 2050/51 (1994), now under MD. The LMIS unit introduced a web-based LMIS in fiscal year 2065/66 and later implemented an online Inventory Management System (IMS) in fiscal year 2073/74 for store management.

The adoption of the eLMIS system at the central, provincial, local levels, and Health Facilities will improve the logistics management information system. Acknowledging the six principles of the logistics management; right commodity, right quantity, right place, right time, right price and right situation, the Logistics Management Division of the Health Services Department has updated the supply chain management system to the eLMIS system from Baishakh 2075 to record information regarding medicine, vaccines and health commodities in near real time to strengthen supply chain management processes and enhance LMIS data entry and visualization, aiding informed decision-making. This system will support other divisions as well in monitoring and policy formulation by providing authentic stock details of the medicine, vaccines, and health commodities immediately.

The eLMIS now covers all local Level stores with plans for extensions to all service delivery points (SDPs) based on operational requirements. As of Ashad 2081, there are a total of 5,425 live sites, comprising 4,504 SDPs, 753 LLGs, 77 Health Offices, and 7 provincial and 7 federal stores. In cases where SDPs await eLMIS implementation, LMIS forms are submitted to LLGs for data entry. eLMIS provides a dashboard that visualizes the stock status, consumption of health commodities, and reporting status. The digitalization of inventory management activities such as handover takeover form (*Hastantaran Faram*), entries in Health Facilities' Supply Registration Book (*Dakhila Register*),

and stock books through eLMIS has significantly reduced the paper-based workload for providers and staff. Additionally, eLMIS ensures the safety of data, providing a secure platform for managing inventory information.

### 5.5.2 Goal and Objective of LMIS

**Goal:** The goal of LMIS is to ensure the availability of quality health commodities at health facilities and the community level round year.

**Objective:** To maintain and move appropriate quantities of essential medicines, vaccines, contraceptives, equipment, HMIS/LMIS forms, and allied commodities (including repair and maintenance of bio-medical equipment) in a timely fashion to places where they are needed, at a reasonable cost.

### 5.5.3 Logistic supply system in Rolpa district

There is a practice of a pull system in the Rolpa district for logistic supply to the peripheral health facilities. In this system, peripheral health facilities like PHC, HP, and BHCC demand the commodities and drugs on a quarterly basis and sometimes immediately if required. HO also demands, accordingly to the Provincial Health Logistic Management Center (PHLMC), the Center Medical Store or even the Logistic Management Section of DOHS. However, the pull system has not been fully put into practice since HO and LLG supply the regular drugs and commodities without the demand of peripheral health facilities.

### 5.5.4 Indicators

#### 5.5.4.1 Current eLMIS online and LMIS sites in Rolpa District in 2081/82 B.S.

Health Facility Type	eLMIS Sites Count	LMIS Sites Count
Health Office	1	0
LLG Stores	10	0
District Hospital	1	0
Municipal Hospital	1	0
HP	48	1
PHCC	2	0
UHC	5	6
CHU	14	24
BHSC	21	1
<b>Total (Rolpa District)</b>	<b>103</b>	<b>32</b>

There were a total of 103 e-LMIS sites in the Rolpa district in the fiscal year 2081/82 B.S.

#### 5.5.4.2 eLMIS Reporting Status by Institutions (%)

Type of Health Facilities	2079/80	2080/81	2081/82
1. PHCC	100	100	100
2. Health Post	100	100	100
3. BHCC	100	100	100
4. CHU/UHC	100	100	100
5. Hospital	100	100	100

The trends of eLMIS reporting status are 100 percent over the last three FYs through all health facilities, including the Hospital. Round the year, no scarcity or stock out of key commodities within the district and peripheral sites. Near-expiry medicine was transferred to nearby high-case-loaded HF for early consumption, which helps to reduce wastage.

#### 5.5.4.3 Palika-Wise eLMIS Reporting Status

Name of LLG	Number of Health Facilities using e-LMIS	e-LMIS Reporting Rate	e-LMIS Reporting Rate on Time
Sunchhahari Rural Municipality	7	100	100
Thabang Rural Municipality	9	100	100
Paribartan Rural Municipality	9	100	100
Gangadev Rural Municipality	9	100	100
Madi Rural Municipality	9	100	100
Tribeni Rural Municipality	7	100	100
Rolpa Municipality	16	100	100
Runtigadhi Rural Municipality	12	100	100
Sunil Smriti Rural Municipality	10	100	100
Lungri Rural Municipality	9	100	100
<b>Rolpa District</b>	<b>97</b>	<b>100</b>	<b>100</b>

There were a total of 97 health facilities using e-LMIs, with a 100% reporting rate on time in the Rolpa district in fiscal year 2081/82 B.S.

### 5.5.5 Major LMIS Activities carried out in FY 2081/82 in Rolpa District

- LMIS, supply chain management, and eLMIS training to health workers
- Budgeting, quantifying, forecasting, procurement, and storage-related training to health coordinators and other related staff.
- Plan and forecast the need for medicine/commodities and procure through the annual budget.
- Store, re-pack, and distribute medicines, vaccines, contraceptives, equipment, and allied commodities.
- Procurement and supply of medical equipment and instruments
- Monitoring and supervision of supply chain management
- Review and discuss regularly regarding the eLMIS recording and reporting status

### 5.5.6 Issues, Recommendations, and Responsibilities

Issues/Challenges	Recommendations	Responsibilities
Irregular and delayed reporting of LMIS forms from health facilities	Ensure timely submission of LMIS reports through regular follow-up, reminders, and supervision.	HO LMIS focal person and Health Facility In-charges.
Limited capacity of staff in logistics and supply chain management	Provide training to storekeepers and facility staff on LMIS recording, stock management, and reporting.	PLMD, PHTC, HO.
Delayed supply and distribution from higher levels	Coordinate regularly with the Provincial Supply Chain Unit and Health Service Directorate to ensure timely delivery.	HO Logistics Officer and PHD Supply Unit
Incomplete inventory records	Conduct regular on-site stock verification and reconcile records with physical counts.	HO LMIS focal person and Store Management Team.
Limited use of LMIS data for decision-making and planning	Promote the use of LMIS reports in procurement planning and the redistribution of stock.	HO

## 5.6 Social Health Insurance Program

### 5.6.1 Introduction

The Health Insurance Program (HIP) in Nepal, initiated in fiscal year 2072/73 from three districts, Kailali, Baglung, and Illam under the Social Health Security Development Committee, is now implemented in all 77 districts. The program is now managed by the Health Insurance Board (HIB) as an autonomous entity, in line with the Health Insurance Act, 2074, and Health Insurance Regulation, 2075.

**Goal:** The ultimate goal of HIP is to contribute to achieving Sustainable Development Goals (SDGs) target 3.8, a commitment to universal health coverage (UHC), financial risk protection, and access to quality essential health services for all.

**Objectives:**

**General Objective:** To ensure access to and utilization of quality health services and guarantee health services for all based on social health insurance.

**Special objectives:**

1. To provide additional financial protection to the general public by arranging prepayment and risk reduction in the health service sector.
2. To ensure equitable allocation of financial resources.
3. To improve the quality, effectiveness, efficiency, and accountability of services during the delivery of health services.

**Strategy:**

1. To actively involve all community groups in health insurance through awareness programs and provide special protection to the poor and low-income groups.
2. To collaborate with public and private health service provider institutions.
3. To gradually expand the program nationwide according to the legal provisions related to health insurance.

### **5.6.2 Features of the Health Insurance Program**

According to the Health Insurance Regulation, 2075, the features of this program are as follows:

1. The health insurance program is based on family contributions, requiring participation of all family members.
2. A family of up to 5 members must pay an annual contribution of Rs. 3500. For families with more than 5 members, an additional amount of Rs. 700 per member must be paid.
3. The health insurance program is based on a voluntary system.
4. All populations in the districts where the program is operated fall under the targeted group according to the Health Insurance Regulation. The targeted groups include senior citizens aged 70 years and above, MDR-TB patients, persons with disabilities (category A), extremely poor, HIV patients, leprosy patients, and female community health volunteers.
5. The benefit package limit is Rs. 100,000 annually for families of up to 5 members. For families with more than 5 members, the limit increases by Rs. 20,000 per additional member. The maximum limit is Rs. 200,000 (two hundred thousand).
6. Under the Health Insurance Program, insured members are entitled to cashless services at government hospitals with up to 15 beds after paying the contribution amount once a year and becoming active members. For government hospitals with more than 15 beds, a 10% co-payment is required, and for private hospitals, up to 20% co-payment must be made. Treatment is arranged according to the facility's limits of the benefit package.
7. Under the Health Insurance Program, insured members can receive health services from all government health-registered institutions, and upon referral with a referral slip, services are also available from private sector hospitals and teaching institutions that have agreements with the Insurance Board.
8. If services are not available at local-level hospitals, referral arrangements are in place to ensure access to specialized services.
9. Membership in the program must be renewed annually. Continuous health services are provided upon renewal, and automatic renewal is arranged for the targeted groups.
10. Membership registration is open throughout the year in districts where the program is implemented. The program is operated using information technology. Registration assistants visit homes with mobile phones to take photos and assist with registration.
11. The Health Insurance Board acts as the purchaser of services, while government and private health institutions provide the services, operating under the provision that the service purchaser and service provider must be distinct entities.
12. Concessions have also been provided on the contribution amount for female community health volunteers, and under the targeted group, senior citizens aged 70 years and above, MDR-TB patients, category A disabled persons, the extremely poor, HIV patients, those with 100% leprosy disability, and female community health volunteers are entitled to a 50% discount.
13. In emergencies, arrangements have been made to receive services from any registered health institution.
14. In this program, out of 1289 types of medicines, 1264 types of allopathic and 25 types of Ayurvedic medicines are made available.

### 5.6.3 Status and Target of Health Insurance Program

Indicator	Lumbini Province Status in 2022	National Status in 2022	SDG Target 2030
Population enrolled in the Health Insurance Program	23%	28%	100%
<b>Source: Annual Health Report of Health Insurance Board, Fiscal Year 2080/81</b>			

### 5.6.4 Health Insurance Program in Rolpa District

The Health Insurance Program was started in Rolpa District in Mangsir 1, 2074 B.S. The program is running in all the 72 wards of 10 palikas in the Rolpa District.

क्र स	विवरण	उपलब्धी
१	जम्मा विमित परिवार	20.5%
२	अति गरिव विमित संख्या	NA
३	सेवा लिएका विमित संख्या	13233
४	सेवा लिएका अति गरिव विमित संख्या	NA
५	जम्मा प्रिमियम संकलन रुपैयामा	8251600

The total number of people insured in the health insurance program was 13233 in the Rolpa district in fiscal year 2081/82 B.S.,

### 5.6.5 Issues with recommendations for the Health Insurance Program:

Issues	Recommendations
A smaller number of people enrolled in the Health Insurance Program	Conduct awareness campaigns about health insurance benefits and simplify enrollment procedures to increase coverage. Offer incentives or subsidies for vulnerable populations to encourage participation.
Low awareness, affordability concerns, and weak renewal systems.	Enhance enrollment by increasing community awareness through radio, ward meetings, FCHVs, and deploying mobile teams in remote areas.
Lack of registered medicines in government health institutions	Strengthen supply chain management to ensure consistent availability of essential and registered medicines. Implement regular audits and proper inventory systems to avoid stockouts.
Lack of quality health services	Enhance training and capacity building for health workers. Introduce quality assurance mechanisms and patient feedback systems to monitor and improve service quality.
Limited tracking of enrollment, claims, and renewals at the district level.	Strengthen monitoring by creating a simple SHI dashboard, conducting quarterly municipal reviews, and integrating SHI data into routine HMIS reports.

## 5.7 Financial Management

### 5.7.1 Introduction

An effective financial support system is imperative for efficient management of health services. Health financing is an important building block and an essential strategic component to ensure UHC and the achievement of SDGs. Preparation of the annual budget, timely disbursement of funds, accounting, reporting, and auditing are the main financial management functions that are necessary to support the implementation of health programs. Evidence suggests that countries should strive to spend 5% of their gross domestic product (GDP), and low and middle-income countries to spend USD 86 per capita to promote access to primary care services. Although the return on investment in health comes back in many folds as that of the investment, political willingness and commitment have been observed to be crucial in terms of the allocation of sufficient funds for health financing.

At present, Nepal has adopted a mixed health care financing system with free BHS, health insurance, targeted social health protection programs, and out-of-pocket expenditure for services not covered through the safety nets in both public and private spheres. A total of 54.2% of the health spending is reported to be from out-of-pocket expenditure.

### 5.7.2 Financial management in the Health Office, Rolpa

The Finance Section of the DoHS is the focal point for financial management for all programs under the DoHS. And now onwards, the annual health program and budget are released in the health office by the Ministry of Health under the Lumbini Province Government.

HO, Rolpa has a finance section, functional with an Account Officer. District planning of annual budget preparation has been carried out in the second quarter, and annual planning was submitted to the higher authority through the Health Directorate, based National Health Policy & Programs, in the designed format of the National and Provincial Planning Commission. There is still a consistent problem with the timely release of funds that has affected the implementation of the health program. Almost all of the financial irregularities (Beruju) have been cleared or submitted for clearance. No additional financial irregularities since the last 6 fiscal years in HO Rolpa. It is a major strength of HO Rolpa.

### 5.7.3 Financial Management in Health Office, Rolpa in FY 2081/82

शशर्त			नशर्त			जम्मा		
अख्तियारी	खर्च	खर्च %	अख्तियारी	खर्च	खर्च %	अख्तियारी	खर्च	खर्च %
26594144	15474499	58.18%	30755000	23082497	75.05%	57349144	38556996	67.23%

## आ.व. २०८१/८२ बार्षिक प्रगति विवरण (स्वास्थ्य कार्यालय, रोल्पा) (बजेट रु०००)

सि.नं.	कार्यक्रमको नाम	कुलबजेट	कुलखर्च	प्रतिशत
१	स्वास्थ्यव्यवस्थापन कार्यक्रम संघ शसर्त अनुदान	१४६००००	१३३६८५०	९१.५७
२	उपचारात्मकसेवा कार्यक्रम संघ शसर्त अनुदान	१४०००००	११६९३८५	८३.५३
३	एकीकृतस्वास्थ्य तथा सरसफाई कार्यक्रमहरु पुँजीगत	५५०००००	४४९९३४४	८०.८०
४	परिवारकल्याण	२१३०००००	१४४९००२६	६८.०३
५	नर्सिडतथा सामाजिक सुरक्षा सेवा कार्यक्रम संघ शसर्त अनुदान	७८०००००	७७०८२०	९८.८२
६	स्वास्थ्यक्षेत्र सुधार कार्यक्रम संघ शसर्त अनुदान	१००००००	२७५०४	२७.५
७	स्वास्थ्यचालु बजेट	१२६६८०००	९७५४०७८	७७
८	एकीकृतस्वास्थ्य तथा सरसफाई कार्यक्रमहरु	१२२८७०००	८५२९५०५	६९.४२
९	क्षयरोगनियन्त्रण संघ शसर्त अनुदान	२६०००००	२५२६७०	९७.१८
१०	परिवारकल्याण पुँजीगत खर्च	३९४१४४	४०००००	१०१.५
११	स्वास्थ्यकार्यालय पुँजीगत	३००००००	२९९५७०	९९.८६
१२	महामारीरोग नियन्त्रण कार्यक्रम संघ शसर्त अनुदान	६००००००	३४२८१०	५७.१४
१३	राष्ट्रियस्वास्थ्य शिक्षा सूचना तथा संचार केन्द्र	३००००००	१८२९०९	६०.९७
जम्मा		५७३४९१४४	३८५५६९९६	६७.२३

## SUPPORTING PARTNER

### 6.1 Introduction

The outcomes discussed above are the results of various government entities, various development partners, national NGOs, the private sector, and other supporting organizations.

Development partners support the government health system through a sector-wide approach (SWAp). The Foreign Aid Policy (FAP) 2002 and Development Cooperation Policy (DCP) 2014 provide a foundational framework for effectively implementing SWAp, ensuring better coordination of external funding.

### 6.2 Development Partners working in Rolpa District

The list of development partners working in the Rolpa district in fiscal year 2081/82 B.S., along with their major program focus, is listed below.

S.N.	Development Partner Name	Major program focus
1.	RUDAS	Sexual, Reproductive, and Health Rights
2.	BNMT	Tuberculosis
3.	Medic Mobile	Digital Health
4.	KIDS	SRHR
5.	Rolpa PLUS	Treatment and Food support for HIV patients
6.	HKI	Multiple Micronutrient Supplementation (MMS) for Pregnant and Lactating Women

### 6.2.1 Rural Development and Awareness Society Nepal

Rural Development and Awareness Society Nepal (RUDAS Nepal), established on January 28, 2005 (B.S. 2061 Magh 15) and registered under Rolpa District Administration Office (No. 73/061/62) with Social Welfare Council affiliation No. 17550, aims to promote a self-reliant society, eradicate poverty, end social discrimination, ensure good governance, and support sustainable development. Its goal is to enhance social awareness, implement programs for sustainable development, and assist the state in building a strong and capable society. RUDAS Nepal works across key areas including health, nutrition, sanitation, agriculture, economic development, food security, gender equality, disability and social inclusion, environment and disaster management, infrastructure, renewable energy, education, and good governance.

In the Rolpa district, RUDAS works focusing on SRHR in Pariwartan and Sunchhari Rural Municipality.

Programs and duration conducted by RUDAS in the health sector in Rolpa district:

- Women Health Program (WHP) operated for 3 years from 2067 BS in 10 former Village Development Committees (VDCs) of Rolpa.
- Suaahara-I (Good Nutrition) Program from 2071 BS to 2080 BS throughout the Rolpa district.
- Safe Abortion Program by IPAS Nepal for only 3 months in 2074 BS.
- Food and Nutrition Security Program for 3 years from 2071 BS in 10 former VDCs.
- The Sexual Reproductive and Health Rights (SRHR) program has been operating since 16th Bhadra 2082 BS in Rolpa district, specifically in the Parivartan and Sunachhuri rural municipalities.

#### **Sexual Reproductive and Health Rights (SRHR) Project:**

Sustainable Empowerment of Sexual and Reproductive Health and Rights and Climate-Resilient Health Service System Project in Nepal

**Goal of the SRHR Project:** Accessible, affordable, and quality safe abortion services, along with other sexual and reproductive health and rights services, will be sustainable at the local level.

#### **Project Objectives:**

- Support capacity development of sexual and reproductive health service systems and service providers, and ensure the continuity of sexual and reproductive health services during climate-related disasters.
- Increase the integration of SRHR and gender equality into local institutional-level activities and climate adaptation budgets, plans, and policy processes.
- Strengthen collective action in local leadership for gender-transformative climate adaptation and disaster response.

### **Program Implementation Procedures (Modality)**

- Climate and Disaster Management,
- Sexual and Reproductive Health and Rights (Capacity building of service providers, advocacy and support for localization of planning and policy processes,
- Community engagement and awareness enhancement.

### **6.2.2 Birat Nepal Medical Trust (BNMT)**

BNMT Nepal, a non-governmental organization established from the legacy of the Britain Nepal Medical Trust (since 1967), works to improve the health and well-being of Nepalese people by supporting government programs on tuberculosis, reproductive, mental, child, and maternal health. It focuses on strengthening local capacities, empowering disadvantaged communities, and developing innovative, equitable, and accessible health care models.

BNMT in the Rolpa district supports the tuberculosis control program of the GoN. The major interventions for the detection of TB by BNMT are:

- Sputum Transportation
- Contact tracing
- Screening of TB among Malnourished Children
- Screening of DR Suspect
- Screening of family members of index DR TB cases
- Tuberculosis Preventive Therapy (TPT) for the children

### **6.2.3 Medic Mobile**

Medic Mobile is a non-profit organization using mobile technology to improve maternal and child health in remote areas by enhancing coordination among health workers and FCHVs. Its mobile health program strengthens existing community health services, aiming to ensure timely antenatal visits, institutional deliveries, and postnatal checkups as per national guidelines, ultimately reducing maternal and child mortality.

In coordination with the Health Office, Rolpa, and all local levels, Medic Mobile implemented a mobile health program across 10 local levels, training 200 health workers and 459 FCHVs to register pregnant women and deliver maternal and child health services.

## 6.2.4 Kapilvastu Integrated Development Services

### Introduction

Kapilvastu Integrated Development Services (KIDS) is a women-led NGO established in 2005, dedicated to building an equitable, healthy, and self-reliant society. Based in Kapilvastu with branches in Butwal, Nawalparasi-West, and Surkhet, KIDS supports marginalized groups by improving access to education, health, and livelihoods while promoting gender equality and social inclusion. It implements programs on reproductive health, tuberculosis, HIV/AIDS, nutrition, and women's empowerment across multiple districts in Nepal.

In Rolpa district, this program is being implemented in Rolpa Municipality and SunilSmriti Rural Municipalities in partnership with UNFPA.

### Major activities conducted in fiscal year 2081/82 B.S.

- A concrete FP micro-plan conducted in SunilsmritiRM and Rolpa Municipality, and a concrete FP micro-plan are available at those palikas.
- A Family Planning and Reproductive Health review was conducted in SunilsmritiRM and Rolpa Municipality, identifying gaps and securing commitments for improvement.
- Supported for printing the health policies of SunilsmritiRM and Rolpa Municipality.
- Conducted implant training to two health service providers, each from SunilsmritiRM and Rolpa Municipality
- Conducted IUCD training to one health service provider each from SunilsmritiRM and Rolpa Municipality
- Health Service Providers from Sulichaur PHCC, Sunilsmriti RM, received orientation on PPF and discussed their roles in ensuring quality services by utilizing missed opportunities.
- Provided support to print out some copies of the Annual Health Report of the Health Office- Rolpa
- DMT training to 13 health workers of Sunilsmirti RM

## 6.2.5 Rolpa PLUS

### Introduction

Rolpa Plus Organization is an institution established in 2065 B.S. for the health care of HIV-infected individuals and advocacy for their rights and interests. This organization is currently providing services to individuals in 8 municipalities within the Rolpa district, except Runtigadhi and Paribartan Rural Municipality.

### Supported by Rolpa PLUS in 2081/82 B.S.

S.N.	Support at Local Level	Number of Beneficiaries	Budget Allocation in NRS.	Budget Expenditure in NRs.
1	Rolpa Municipality	8	50000	Travel and treatment=30000, Food support=20000
2	Lungri Rural Municipality	10	80000	Travel and treatment=40000, Food support=40000
3	Thabang Rural Municipality	5	50000	Travel and treatment=33000, Food support=17000
4	Tribeni Rural Municipality	2	10000	Travel =4420, Food support=5580

**Best Practices:** Coordinated the disbursement of scholarship funds and facilitated the first viral load sample collection from the district hospital.

## 6.2.6 Helen Keller International (HKI)

Helen Keller International (HKI) has been working in Nepal since 1989 to improve the sight and lives of the vulnerable by combating the causes and consequences of blindness, poor health, and malnutrition through public health approaches, building the capacity of organizations, and contributing to policy changes through systems strengthening and operations research.

In the Rolpa district, HKI has implemented Multiple Micronutrient Supplementation (MMS) for Pregnant and Lactating Women in Nepal as Implementation Research.

Helen Keller International, in collaboration with the Family Welfare Division and partners like MoHP, UNICEF, WFP, and the Eleanor Crook Foundation, is leading implementation research to support Nepal's transition from iron and folic acid (IFA) to multiple micronutrient supplements (MMS) for improved maternal and infant health. Following national and provincial stakeholder workshops and district-level sensitization meetings, a mixed-methods study is underway across all seven provinces—an RCT in Lumbini and demonstration studies elsewhere—to assess MMS acceptability, adherence, and feasibility. Complementary qualitative research and regulatory discussions are also ongoing to inform the inclusion of MMS in Nepal's Essential Medicines List. The study's findings will guide evidence-based policy decisions for Nepal and similar global contexts.

**6.3 Issues and Recommendations for support from development partners:**

<b>Issues</b>	<b>Recommendations</b>
1. Limited coordination between development partners and local health authorities	Establish a regular coordination mechanism and joint planning meetings among the Health Office, local governments, and partners
2. Duplication of activities in similar program areas	Conduct mapping of partner interventions and promote integrated, complementary approaches
3. Insufficient alignment with government health priorities and plans	Ensure all partner programs are aligned with the national and provincial health policies and the Annual Work Plan and Budget (AWPB)
4. Irregular reporting and weak monitoring systems	Strengthen joint supervision, monitoring, and reporting mechanisms with standardized tools and develop a unified information-sharing platform between the HO and development partners
5. Short-term project cycles limit sustainability	Encourage partners to develop long-term strategies and build local capacity for program continuity

अनुसूचीहरू (ANNEXES)

अनुसूची-१ : Top Ten Diseases (Three Years Trends)

FY 2079/80	FY 2080/81	FY 2081/82
Headache	Headache	Fever
Gastritis (APD)	Fever	Cough
Fever	Gastritis	Itching
Upper Respiratory Tract Infection (URTI) Cases	Cough	Abdominal Pain
Presumed Non-Infectious Diarrhoea Cases	Upper Respiratory Tract Infection (URTI) Cases	Arthritis
Cough	Presumed Non-Infectious Diarrhoea Cases	Fatigue and Weakness
ARI/Lower Respiratory Tract Infection (LRTI) Cases	Cut/Injuries	Nausea and Vomiting
Typhoid (Enteric Fever) Cases	Abdominal Pain	Chest Pain
Backache (Musculoskeletal Pain)	Musculoskeletal Pain	Dizziness
Cut injuries	Lower Respiratory Tract Infection (LRTI) Cases	Lower Back Pain

अनुसूची २: ८० वर्ष माथिका जेष्ठ नागरिक तथा अति अशक्त नागरिकलाई घरमै स्वास्थ्य सेवा अन्तर्गतका सेवाग्राहिहरूको विवरण

पालिकाको नाम	८० वर्ष माथिका जेष्ठ तथा क र ख वर्गका नागरिकलाई सेवा दिँएको संख्या			मुख्य रोगहरूको विवरण
	महिला	पुरुष	जम्मा	
सुनछहरी गा.पा.	१८७	१४९	३३६	Backache, URTI, Conjunctivitis, Weakness, Wound, Arthritis, Diarrhoea, Abdominal Pain, Asthama, Cough, Gastritis, Rhinitis, Fever, Headache, Chest Pain, Joint Pain, Knee Pain, Eye Infection, Toothache, Fever, Wound, Fever, HTN, Dizziness, Worm Infection, Bodyache, Allergy, Stomatitis, Monopleyia, Pneumonia, Leg Pain, Fungal Infection, Tonsilitis, Leg Pain, NAD, Oedema, Paralysis, ARI, Ear Infection, Cut Injury, Abscess, Rhinitis
थबाङ गा.पा.	१३२	१३४	२६६	
परिवर्तन गा.पा.	१९१	१४६	३३७	
गंगादेव गा.पा.	१०५	१२२	२२७	
माडी गा.पा.	१२७	१४०	२६७	
त्रिवेणी गा.पा.	११८	१५८	२७६	
रोल्पा न.पा.	२०६	१८०	३८६	
रुण्टीगढी गा.पा.	९५	१३६	२३१	
सुनिलस्मृति गा.पा.	२८३	३०२	५८५	
लुङ्ग्री गा.पा.	१७४	२३२	४०६	
<b>जम्मा</b>	<b>१६८८</b>	<b>१६९९</b>	<b>३३९७</b>	

अनुसूची ३: रोल्पा जिल्लामा सञ्चालित एम्बुलेन्स सेवाको विवरण

क्र सं	संस्थाको नाम	एम्बुलेन्स रहेको पालिका	दि/मा/सं	संचालन भएको र नविकरण भएको अन्तिम मिति	जीपीएस बडान भए / नभएको	चालकको नाम र सम्पर्क नम्बर	तालिम लिए / नलिएको	संचालकको नाम र सम्पर्क नम्बर	दि/मा/सं
१	रोल्पा अस्पताल, रेउघा	रोल्पा नगरपालिका	ग	२०७७/१०/०४ र २०८१/१०/०३	भएको	कुमार बली ९८६६९३५११०	नलिएको	रोल्पा अस्पताल	
२	प्राथमिक स्वास्थ्य केन्द्र, होलेरी रुण्टिगाडी	रुण्टिगाडी गाउँपालिका	ग	०४/२९/२०८२	नभएको	रमेश श्रेष्ठ ९७६८३०५६९८	लिएको	रुण्टिगाडी गाउँपालिका	
३	सयपत्रीकण तथा सहकारी संस्था परिवर्तन गा.पा. बागमारा	परिवर्तन गा.पा.	ग	नविकरण नभएको	नभएको	नवराज बाटा ९८६६५०५१३०	नलिएको		
४	परिवर्तन गा पा			संचालन नभएको		कुलप्रसाद शर्मा ९८४८०५८५३४			
५	मंगानेव गा पा	मंगानेव गा पा	ग	१०/१५/२०८१	जडान भएको तर हाल विप्रेको	इन्द्रबहादुर बली ९८४४५७८२९७	नलिएको	मंगानेव गा पा	
६	स्वास्थ्य चौकी खुडगी	सुनिलस्मृति गा पा	ग	२०८२ माइ	भएको	ठाकुर महारा ९८६३१४०५०५	नलिएको	नेत्र बहादुर गिरी ९८५७८१४७८	
७	प्राथमिक स्वास्थ्य केन्द्र, सुनिलस्मृति	सुनिलस्मृति गा पा	ग	०२/२३/२०८२	जडान भएको तर काम नभएको	बखान चौधरी ९८४३५३८६४४	नलिएको	ओबिलाल बस्नेत ९८६६५०५१७७	
८	स्वास्थ्य चौकी गजुल	सुनिलस्मृति गा पा	ग	०४/१०/२०८२	जडान भएको तर काम नभएको	सुरेन्द्र थापा ९८१०९०५७३९	नलिएको	लोकेश्वर बहादुर थापा ९८४१२४८०६४	
९	स्वास्थ्य चौकी तेवाङ	सुनिलस्मृति गा पा	ग	१०/१६/२०८२	जडान भएको तर काम नभएको	पूर्ण बहादुर बिस्ट ९८६९६९९४०९	नलिएको	रेशम शर्मा रिजाल ९८४७९४४२९६	
१०	सुनौदय सहकारी संस्था रुइनिवाङ	सुनिलस्मृति गा पा	ग	२०८२ जेष्ठ	नभएको	खड्ग बुढायोकी ९८४२५१६२५१	नलिएको	अमृत बहादुर थापा ९८४२५१६२५१	
११	बडाचौर स्वास्थ्य चौकी	लुङ्गी गा पा	ग	०१/१२/२०८१	नभएको	तिलक घाँति मगर ९८६४४४५०९२	नलिएको	तेपेन्द्रबहादुर बुढायोकी ९८५७८५५०२२	
१२	पोवाङ स्वास्थ्य चौकी	सुनछहरी गा पा	ख	२०७९ फाल्गुन १२ नविकरण नभएको	भएको तर काम नभएको	द्विजिज पुन ९८४०१५७६७७	नलिएको	बशुधा बिस्ट ९८४७८५०८८५	
१३	थाबांग आधारभूत अस्पताल	थवाङ गा पा	ख	०१/१९/२०७९	भएको	एन्जिल बुढामगर ९७६७५०५९४१	नलिएको	राजकुमार बुढामगर ९८४२५१७५१७	
१४	नुवागाउँ स्वास्थ्य चौकी	त्रिवेणी गा पा	ख	२०८१/०५/१९	भएको	शम्भु बहादुर ओली ९८४९८९८३३२२	नलिएको	विष्णु पौडेल ९८४२२९०३६०	
१५	नेपाँ स्वास्थ्य चौकी	त्रिवेणी गा पा	ख	२०७७/३/११ र २०८२/०४/२५	नभएको	धिरेश्वर डोँगी ९८६६५०६७८१	नलिएको	खगेन्द्र घतिमगर ९८६६०१४४२९	
१६	माडी गा पा	माडी गा पा	ग	२०७७/०९/०१ र २०८२/३/१२	भएको	मनोज बाटा मगर ९८६७७९३३५०	नलिएको	माडी गा पा	
१७	कोचाबाङ्ग स्वास्थ्य चौकी	माडी गा पा	ख	२०७९/११/२९ र २०८१/१२/२८	भएको	श्याम बहादुर घाँति ९८४३७०११७	नलिएको	नेपाल रेडक्रस सोसाईटी घर्तीगाउँ उपशाखा ९८५७८२५३६३	

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अनुसूची ४ : जिल्लाका सबै स्थानीय तह स्तरीय बार्षिक समिक्षा गोष्ठीको अबसरमा आ.व.२०८१/८२ को स्वास्थ्यका सूचकका आधारमा स्थानीय तहले मुल्यांकन गर्दा प्रथम स्थान हासिल गरेका स्वास्थ्य संस्थाहरु मध्येबाट जिल्ला स्तरमा उत्कृष्ट हुन सफल स्वास्थ्य संस्थाहरुको विवरणः

क्र.स.	स्वास्थ्य संस्थाको नाम	प्रासाङ्क	आ.व.२०८१/८२ मा प्राप्त स्थान (Rank)	गत.आ.व.२०८०/८१ को स्थान
१	सुलिचौर प्रा.स्वा.के.	८२.५६%	१	४
२	थवाङ आधारभुत अस्पताल	७९.५९%	२	१
३	घर्तीगाँउ स्वास्थ्य चौकी	७९.२२%	३	५
४	नेर्पा स्वास्थ्य चौकी	७६.१४%	४	२
५	मसिना स्वास्थ्य चौकी	७५.७५%	५	३
६	केवरी स्वास्थ्य चौकी	७५.६६%	६	
७	हार्जङ स्वास्थ्य चौकी	७४.८४%	७	
८	ओत स्वास्थ्य चौकी	७३.०२%	८	८
९	जेदवाङ स्वास्थ्य चौकी	७०.०७%	९	
१०	सिउरी स्वास्थ्य चौकी	६९.६८%	१०	

अनुसूची ५ : आ.व. २०८१/८२ को स्वास्थ्यका मुख्य मुख्य सूचकका आधारमा मुल्यांकन गरि स्वास्थ्य कार्यालय रोल्पाले संचालन गरेको बार्षिक समिक्षा गोष्ठीको अबसरमा गरिएको जिल्लाका स्थानीय तहहरुको मुल्याङ्कन विवरणः

क्र.स.	स्थानीय तहको नाम	प्रासाङ्क	आ.व.२०८१/८२ मा प्राप्त स्थान (Rank)	गत.आ.व.२०८०/८१ को स्थान
१	सुनिलस्मृति गाउँपालिका	७३.९३%	१	२
२	रुण्टीगढीगाउँपालिका	७३.८९%	२	६
३	त्रिवेणी गाउँपालिका	७३.६२%	३	३
४	थवाङ गाउँपालिका	७२.१८%	४	१
५	लुङ्ग्री गाउँपालिका	७१.७६%	५	४
६	रोल्पा नगरपालिका	६९.८७%	६	७
७	माडी गाउँपालिका	६९.८६%	७	५
८	परिवर्तन गाउँपालिका	६८.६६%	८	६
९	गंगादेव गाउँपालिका	६६.८४%	९	९
१०	सुनछहरी गाउँपालिका	६१.४२%	१०	८

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अनुसूची ६ : पूर्ण खोप दिगोपना तथा सुनिश्चितता घोषणा समारोह कार्यक्रम २०८१/८२ मा उत्कृष्टरूपमा सम्मानित खोप कार्यमा संलग्न स्वास्थ्यकर्मीहरूको नामावली विवरणः

क्र.स	नाम थर	पद	कार्यालय
१	भिमा कुमारी घर्ति मगर	सि.अ.न.मि. छैठौं	तालाबाड स्वास्थ्य चौकी
२	धनराज सुवेदी	सि.अ.हे.व	धवाड स्वास्थ्य चौकी
३	मिना रोका मगर	अ.न.मि	हार्जड स्वास्थ्य चौकी
४	तिलक राज डाँगी	अ.हे.व	केवरी स्वास्थ्य चौकी
५	नरेश खडका	सि.अ.हे.व	पाखापानी स्वास्थ्य चौकी
६	सीता पुन मगर	अ.हे.व	जौली पोखरी स्वास्थ्य चौकी
७	फुलमाया बुढा मगर	अ.न.मि	सा.स्वा.से.ई.ठुलो गाउँ मिरुल
८	प्रेमकुमारी बुढा	अ.न.मि	जेलबाड स्वास्थ्य चौकी
९	कृपाराम घर्ती	सि.अ.हे.व	बुढागाउँ स्वास्थ्य चौकी

अनुसूची ७ : पूर्ण खोप दिगोपना तथा सुनिश्चितता घोषणा समारोह कार्यक्रम २०८१/८२ मा दिर्घ सेवा सम्मानबापत संघीय एवं प्रदेश सरकारबाट सम्मानित महिला स्वास्थ्य स्वयं सेविकाको नामावली विवरणः

क्र.स	नाम थर	स्थानीय तहको नाम	वडा नम्बर	सम्पर्क नम्बर
१	शान्ति देवी पुन	परिवर्तन गाउँपालिका	२	९८४५७७४६७५
२	लालसरा बुढा मगर	सुनछहरी गाउँपालिका	३	९८६४४४६०८४
३	चन्द्रा घर्तिमगर्नी	सुनछहरी गाउँपालिका	२	
४	हस्तमा घर्ती	सुनछहरी गाउँपालिका	४	९७६५८७७६७५
५	भिमला खत्री (भ्याली खत्री)	सुनिलस्मृति गाउँपालिका	१	९८२२९८०५२८
६	दिर्घा सेन	सुनिलस्मृति गाउँपालिका	२	९८६३५०२०६५
७	तेजी थापा	सुनिलस्मृति गाउँपालिका	२	९८४३४६३०६९
८	चन्द्रा शाह	सुनिलस्मृति गाउँपालिका	२	९८४७८८९७७९
९	मनी घर्ती	रुण्टिगढी गाउँपालिका	१	
१०	श्यामा घर्ती	लुंग्री गाउँपालिका	७	

अनुसूची ८ : जिल्ला द्रुत प्रतिकार्य टोली (RRT) विवरण

जिल्ला द्रुत प्रतिकार्य टोली रोल्पा			
जिम्मेवारी	नाम	पद	सम्पर्क नम्बर
संयोजक	सीता कवंर	नि. कार्यालय प्रमुख स्वा.का. रोल्पा	९८५७८२६७३१
सदस्य	डा. ऋषभ गौतम	मे.अ. रोल्पा अस्पताल	९८४३५४४४५०
सदस्य	जित बहादुर डाँगी	जिल्ला RRT फोकल पर्सन	९८४४९१८१८२
सदस्य	डिल्ली ब. के.सी.	ज.स्वा.नि. स्वा.का. रोल्पा	९८५७८२५७१७
सदस्य	माधव राउत	ज.स्वा.नि. स्वा.का. रोल्पा	९८४७८२२४६६
सदस्य	अरुण भित्तु उपाध्याय	अधिकृत तथ्याङ्क	९८५८०२०१२०
सदस्य	हंसराज केसी	प्रयोशाला प्रतिनिधि रोल्पा अस्पताल	९८५७८३४७४९
सदस्य	नौल सिंह पुन	रेडक्रस सभापति ने रे सो रोल्पा	९८४१५९२८९७
सदस्य	कुल बहादुर डाँगी	रोल्पा अस्पताल इमर्जेन्सि वा फार्मेसी वा भण्डार शाखा प्रतिनिधि	९८४४९४८५५३
सदस्य	लक्ष्मि पौडेल	नर्सिङ प्रतिनिधि रोल्पा अस्पताल	९८४५०८८७८७
सदस्य	शर्मिला पोखेल	पहेन / स्टाफ नर्स	९८५७८२२२९४

अनुसूची १ : Name of All Government Health Facilities of Rolpa District including Birthing Center, IUCD, Implant MA Site and RUSG sites in district along with numbers of SBA

S N	Name of LLG	W N	Names of Health Facility	BC	IUCD Site	Implant Site	MA Site	RUSG Sites	No. of SBA
1	Thabang RM	1	CHU_KHERBANG	NO	NO	NO	NO	2	5
			THABANG_BASIC_HOSPITAL	YES	YES	YES	YES		
		2	BHSC_CHERLOBANG	YES	NO	NO	NO		
			CHU_THULOGAUN MIRUL	YES	NO	YES	NO		
		3	CHU_VITRIBAAN	NO	NO	NO	NO		
2	Paribartan RM		MIRUL_HP	YES	YES	YES	YES	1	6
		4	BHSC_GHORABANG	YES	NO	NO	YES		
			CHU_THARPU	NO	NO	NO	NO		
		5	UWA_HP	YES	NO	YES	YES		
		1	KURELI_HP	YES	NO	YES	YES		
3	Paribartan RM	2	CHU_DADAGAUN_RANGSI	NO	NO	NO	NO	1	6
			RANGSI_HP	YES	YES	YES	YES		
			CHU_BAGHMARA	YES	NO	YES	YES		
		3	KEWARI_HP	YES	NO	YES	NO		
		4	PACHHABANG_HP	YES	NO	NO	YES		
		5	RANGKOT_HP	YES	YES	YES	YES		
6	Paribartan RM		CHU_TRIVENIKHOLA	NO	NO	NO	NO	1	6
			BHSC_NAAFE	NO	NO	NO	NO		
		6	CHU_OBANG	NO	NO	NO	NO		

Health Office, Rolpa

S	N	Name of LLC	W	N	Names of Health Facility	BC	IUCD Site	Implant Site	MA Site	RUSG Sites	No. of SBA
3		Madi RM	1	2	CHU_PEDIKHOLA	NO	NO	NO	NO	1	4
					BHSC_OAT_GHORNETHI	NO	NO	NO	NO		
					GHARTIGAUN_HP	YES	NO	YES	YES		
					CHU_BYANGKHOLA	NO	NO	NO	NO		
					TALAWANG_HP	YES	NO	YES	YES		
					BHSC_KHARSUDANDA	NO	NO	NO	YES		
4		Lungri RM	1	2	BHAWANG_HP	YES	NO	YES	YES	1	5
					CHU_BHAWANG	NO	NO	NO	NO		
					KORCHABANG_HP	YES	NO	YES	NO		
					PANG_HP	YES	YES	YES	NO		
					PANG_CHU	NO	NO	NO	NO		
					AIPE_CHU	NO	NO	NO	NO		
4		Lungri RM	2	3	SIRPA_HP	YES	YES	YES	YES	1	5
					CHU_TALLO SIRPA_	NO	NO	NO	NO		
					BHSC_JUTUNGKHOLA	YES	NO	NO	NO		
					CHU_GOTHECHOUR	NO	NO	NO	NO		
					CHU_SIMLENI	NO	NO	NO	NO		

S	Name of LLC	W	N	Names of Health Facility	BC	IUCD Site	Implant Site	MA Site	RUSG Sites	No. of SBA		
5	Gangadev RM	4		BHSC_NAMJA	YES	NO	YES					
				CHU_SALDANDA	NO	NO	NO	NO				
		5		WADACHOUR_HP	YES	YES	YES	YES				
				CHU_GOTHEKARKA	NO	NO	YES	NO	NO			
				CHU_GOTHIBANG	NO	NO	NO	NO	NO			
		6		CHU_TALLOSEWAR	NO	NO	NO	NO	NO	NO		
				CHU_LALUBANG	NO	NO	NO	NO	NO	NO		
				GUMCHAL_HP	YES	NO	YES	YES	YES			
		7		CHU_PATHEGUMCHAL	NO	NO	NO	NO	NO	NO		
				CHU_BERI	NO	NO	NO	NO	NO	NO		
		1		HARJANG_HP	YES	NO	NO	YES	NO	NO		
				CHU_HARJANG	NO	NO	NO	NO	NO	NO		
		2		1	WOT_HP	YES	YES	YES	YES	YES		
				2	CHU_GAMTHALE	NO	NO	NO	NO	NO		
JINAWANG_HP	YES				YES	YES	YES	YES				
3	BHSC_KUKURGHARE			YES	YES	YES	NO	YES				
4		CHU_KILTHOKE	NO	NO	NO	NO	NO	NO				
		PAKHAPANI_HP	YES	NO	NO	YES	YES					
6								2				

S	Name of LLC	WN	Names of Health Facility	BC	IUCD Site	Implant Site	MA Site	RUSG Sites	No. of SBA
6	Sunchhari RM	5	BHSC_LODHCHAUR	NO	NO	NO	NO		
		6	BHSC_GORJALE	NO	NO	NO	NO		
		7	RAAK_HP	YES	NO	YES	YES		
		1	SERUM_HP	YES	NO	NO	YES		
			CHU_GHUSBANG	NO	NO	NO	NO	NO	
		2	CHU_FULIWAAN	NO	NO	NO	NO	NO	
			BHSC_BHITRIGAM	NO	YES	NO	NO	NO	
		3	CHU_JHELUNGKHUNG	NO	NO	NO	NO	NO	
			GAAM_HP	YES	YES	YES	YES	YES	
			SIURI_HP	YES	NO	YES	YES	YES	
		4	CHU_JHINGA	NO	NO	NO	NO	NO	1
			POWANG_HP	YES	YES	YES	YES	YES	
		5	CHU_RADUNG	NO	NO	NO	NO	NO	
			CHU_NARBANG	NO	NO	NO	NO	NO	
6	FAGAM_HP	YES	YES	YES	YES	YES			
	CHU_DHANSI	NO	NO	NO	NO	NO			
7	JAILWANG_HP	YES	NO	NO	NO	YES			
7	Tribeni RM	1	KARETI_HP	YES	NO	YES	2	10	

**Health Office, Rolpa**

NS	Name of LLC	WN	Names of Health Facility	BC	IUCD Site	Implant Site	MA Site	RUSG Sites	No. of SBA
8	Sunismriti RM	2	NUWAGAUN_HP	YES	YES	YES	YES		
		3	BHSC_LINGDUNG	YES	NO	YES	NO		
		4	BUDAGAUN_HP	YES	YES	YES	NO		
		5	NEPRA_HP	YES	YES	YES	YES		
		6	BHSC_DHARAMKHOLA	NO	NO	NO	NO		
		7	GAIRIGAUN_HP	YES	NO	YES	YES		
		1	GHODAGAUN_HP	YES	YES	YES	YES		
		2	KHUNGRI_HP	YES	YES	YES	YES		
9	Runtigadi RM	2	CHU_CHYANDHARA	NO	NO	NO	NO		
		3	CHU_GOGANPANI	NO	NO	NO	NO		
		3	BHSC_MIGHING	NO	NO	NO	NO		
		4	SULICHOUR_PHC	YES	YES	YES	YES	1	10
		5	BHSC_GAJUL	NO	NO	NO	NO		
		6	CHU_QUALIGAUN	NO	NO	NO	NO		
		6	GAJUL_HP	YES	YES	YES	YES		
		7	TEWANG_HP	YES	YES	YES	YES		
9	Runtigadi RM	8	ARESH_HP	YES	YES	YES	YES		
		1	BHSC_RANJAT	NO	NO	NO	NO		
		2	JAULIPOKHARI_HP	YES	YES	YES	YES	1	9
		3	BHSC_JAWANG	YES	YES	YES	NO		

**Health Office, Rolpa**

S	Name of LLC	W	Names of Health Facility	BC	IUCD Site	Implant Site	MA Site	RUSG Sites	No. of SBA
10	Rolpa Mun.	4	MASINA_HP	YES	YES	YES	YES		
		5	DUBIDANDA_HP	YES	YES	YES	NO		
			CHU_SAIBANG	NO	YES	YES	NO		
		6	DUBRING_HP	YES	YES	YES	YES		
			HOLERI_PHC	YES	YES	YES	YES		
		7	JHENAM_HP	YES	YES	YES	NO		
		8	BHSC_MELTAKURA	NO	NO	YES	NO		
		9	BHSC_SARPAL	NO	NO	NO	NO		
			CHU_GUNAM/PYURI	NO	NO	NO	NO		
		1	BHSC_BAJBISAUNA	NO	NO	NO	NO		
			UHC_HARIGATNA	NO	NO	NO	NO		
		2	UHC_KHEWASE	NO	NO	NO	NO		
			BHSC_DEURALI	NO	NO	NO	NO		
		3	ROLPA_HOSPITAL (GOVT)	YES	YES	YES	YES		
			KHUMEL_HP	YES	YES	YES	YES		
		4	LIWANG_HP	YES	NO	NO	YES		
			JEDBANG_HP	YES	YES	YES	YES		
		5	UHC_JAGATIPOKHARA	NO	NO	NO	NO		
KOTGAUN_HP	YES		YES	YES	YES				
6									
									11

NS	Name of LLG	WN	Names of Health Facility	BC	IUCD Site	Implant Site	MA Site	RUSG Sites	No. of SBA
			UHC_KOTGAUN_DARBOT	NO	NO	NO	NO		
			UHC_KOJAK_DEURALI	NO	NO	NO	NO		
		7	BHSC_GHAPA	NO	NO	YES	NO		
			UHC_MADICHAUR	NO	NO	NO	NO		
			JANKOT_HP	YES	YES	YES	YES		
		8	UHC_NAMLI	NO	NO	NO	NO		
			UHC_GAIRAKHUTI	NO	NO	NO	NO		
			WHAMA_HP	YES	YES	YES	NO		
		9	UHC_WHAMA	NO	NO	NO	NO		
			DHAWANG_HP	YES	YES	YES	NO		
		10	UHC_GAPA	NO	NO	YES	NO		
			UHC_DHANSHI	NO	NO	NO	NO		
	<b>Total</b>	<b>72</b>	<b>123</b>	<b>63</b>	<b>29</b>	<b>59</b>	<b>46</b>	<b>13</b>	<b>73</b>

अनुसूचि-१० : स्वास्थ्य कार्यालय, रोल्पामा कार्यरत कर्मचारीहरूको विवरण

क्र. सं.	नाम थर	पद	सम्पर्क नम्बर	इमेल ठेगाना
1	सिता कँवर	कार्यालय प्रमुख	९८५७८२६७३९	kaworsita@gmail.com
2	जितबहादुर डाँगी	ल्याव टेकिनसियन निरिक्षक	९८४४९९८९८२	jitbdrdangi@gmail.com
3	माधव राउत	जनस्वास्थ्य निरिक्षक	९८४७८२२४६६	Madhav2078@iom.edu
4	डिल्ली के.सी.	जनस्वास्थ्य निरिक्षक	९८५७८२५७९७	kcdb40@gmail.com
5	अरुण भित्तु उपाध्याय	अधिकृत तथ्यांक	९८५७८७७०९५	hellov2g@gmail.com
6	मनिषा खनाल	वरिष्ठ प्रशासन सहायक	९८६७३२८५४८	khanalmanisha57@gmail.com
7	संदिप ढुंगाना	जन स्वास्थ्य अधिकृत	९८६७४९८९९०	sandipdhungana333@gmail.com
8	तिलसरी गुरुङ	कोल्डचेन असिष्टेन्ट	९८५७८६६९६७	nanugurung2076@gmail.com
9	तपेन्द्र के.सी.	कोल्डचेन असिष्टेन्ट	९८६८६६४९७५	kctapendra33@gmail.com
10	हिराबहादुर डाँगी	कार्यालय सहयोगी	९८६६९०६९९९	
11	जयन्द्र थापा	हलुका सवारी चालक	९८४३९९५७०३	
12	फिरोज बुढा	कार्यालय सहयोगी	९८४६९२३८८९	
13	शिशिर सुवेदी	कार्यालय सहयोगी	९८६९८७४५०८	

## Health Office, Rolpa

अनुसूचि-११: रोल्पा जिल्ला स्थित सबै स्थानीय तहका स्वास्थ्य शाखामा कार्यरत कर्मचारीहरुको नामावली विवरण

S. N.	Rural / Municipality	Name	Contact No.	Email
1	Rolpa Municipality	Tank Giri	9857851262	<a href="mailto:tankgiri20@gmail.com">tankgiri20@gmail.com</a>
		Naina Kumari Dangi	9847850735	<a href="mailto:nkdangi2074@gmail.com">nkdangi2074@gmail.com</a>
		Deependra B.K.	9849744126	<a href="mailto:deepenbc35@gmail.com">deepenbc35@gmail.com</a>
2	Sunilsmirty RM	Motim Aalam	9866906167	<a href="mailto:motim.alam30@gmail.com">motim.alam30@gmail.com</a>
		Sabitra Kumari Thapa	9857849020	<a href="mailto:sabitrathapa160@gmail.com">sabitrathapa160@gmail.com</a>
		Sumitra Pandey	9843727204	<a href="mailto:summipandey027@gmail.com">summipandey027@gmail.com</a>
3	Lungri RM	Lependra Budhathoki	9857855022	<a href="mailto:lependrabc@gmail.com">lependrabc@gmail.com</a>
		Dipa Kumari Bista	9866906167	<a href="mailto:dipabista1122@gmail.com">dipabista1122@gmail.com</a>
		Kumari Bista	9846101853	<a href="mailto:kumaribista211@gmail.com">kumaribista211@gmail.com</a>
4	Sunchhahari RM	Jagat Bahadur Buddha	9847868492	<a href="mailto:jagat.budha29@gmail.com">jagat.budha29@gmail.com</a>
		Pavitra K.C.	9868057089	<a href="mailto:pabitakc552@gmail.com">pabitakc552@gmail.com</a>
5	Thawang RM	Tul Bahadur Pun	9851229573	<a href="mailto:pmtul07@gmail.com">pmtul07@gmail.com</a>
		Sarmila Chaudhary	9840530114	<a href="mailto:sharmilachaudharu80@gmail.com">sharmilachaudharu80@gmail.com</a>
6	Paribartan RM	Deepak Ghartimagar	9868626627	<a href="mailto:dipakghartimagar96@gmail.com">dipakghartimagar96@gmail.com</a>
		Nanda Buddha	9857085988	<a href="mailto:nanda2602122@gmail.com">nanda2602122@gmail.com</a>
		Nirmal Buddha Magar	9860035404	<a href="mailto:mnirmal929@gmail.com">mnirmal929@gmail.com</a>
7	Madi RM	Jaya Prakash Buddha	9855046512	<a href="mailto:jayamagar25@gmail.com">jayamagar25@gmail.com</a>
		Dil Kumari Buddha	9843782039	<a href="mailto:dilubudha6@gmail.com">dilubudha6@gmail.com</a>
8	Gangadev RM	Sakal Deo Yadav	9847984244	<a href="mailto:yadavsakaldev78@gmail.com">yadavsakaldev78@gmail.com</a>
		Narahari Nath Yogi	9829584702	<a href="mailto:naraharinath76@gmail.com">naraharinath76@gmail.com</a>
9	Tribeni RM	Purna Bdr Budha	9857824142	<a href="mailto:completemagar@gmail.com">completemagar@gmail.com</a>
		Krishna Kumari B.C.	9840366244	<a href="mailto:krishnabudha702@gmail.com">krishnabudha702@gmail.com</a>
10	Runtigadi RM	BuddhijeeviSejwal	9857850110	<a href="mailto:buddhijeevisejwal@gmail.com">buddhijeevisejwal@gmail.com</a>
		Asiya Bista	9845440393	<a href="mailto:bistaashiya@gmail.com">bistaashiya@gmail.com</a>

**अनुसूचि-१२: Target Population (FY 2081/82)**

Shrawan 2081 - Asar 2082	
Organization	Target Pcp - Total population
502 ROLPA	232480
50201 Sunchhahari Rural Municipality	17104
50202 Thabang Rural Municipality	10632
50203 Paribatan Rural Municipality	21431
50204 Gangadev Rural Municipality	21517
50205 Madi Rural Municipality	17750
50206 Tribeni Rural Municipality	23116
50207 Rolpa Municipality	35787
50208 Runtgadhi Rural Municipality	28068
50209 Suni Smriti Rural Municipality	30574
50210 Lungri Rural Municipality	26501
	Target: pop - Population under 1 year
	Target pop - Pop (6-11 months)
	Target pop - Pop (6-23 months)
	Target pop - Population 12 - 23 months
	Target pop - Pop (0-23 Month)
	Target pop - Population aged 6-59 months
	Target pop - Pop (1-2-59 Month)
	Target pop - Population under 5 years ARI/CDD/ Nutrition
	Target: pop - Total expected live birth
	Target pop - Total expected pregnancies
	Target pop - Married Female population aged 15-49 years
	Target pop - Female population aged 15-49 years



क्र. नं.	कार्यालयको नाम	कार्यालय प्रमुखको नाम र श्रेणी	पद	कार्यालयको सम्पर्क नं.	कार्यालय प्रमुखको नो.बहाल नं.	सुचना अधिकारीको नाम	सुचना अधिकारीको नो.बहाल नं.	कार्यालयको ईमेल ठेगाना	फेसबुक ठेगाना
११	सडक पूर्वाधार विकास कार्यालय	हेमन्त कुमार श्रेष्ठ	का.प्र.	०८६४४००४४	९८४७८२७९३७	लोकमान्व श्रेष्ठ	९८४७८२७९३७	idolorolpa@gmail.com	
१२	शहरी विकास तथा भवन कार्यालय	नारायण बस्ती	का.प्र.		९८४७८२७९३७			udborolpa@gmail.com	
१३	डिभिजन वन कार्यालय रोल्पा	प्रेम शहर चौधरी	डि.प्र.	०८६४४००१२	९८४७८२७९३७	दशराम चौधरी	९८४७८२७९३७	dolorolpa12@gmail.com	
<b>बिना स्थित आयोजना कार्यालयहरू</b>									
१	शान्तिचोक सडक योजना, रोल्पा	साजन प्रसाद श्रेष्ठ	का.प्र.	०८६४४००६२	९८४७८२७९३७	सुमान सुब्बा	९८४७८२७९३७	shahidmargu.rolpa@gmail.com	www.facebook.com/shahidmargu.rolpa
२	ग्रामीण सडक योजना श्रमिक आजीविका रोल्पा	वीर बहादुर श्रेष्ठ	डि.ई.	०८६४४००६२	९८४७८२७९३७	विमल श्रेष्ठ	९८४७८२७९३७	rolpa@gmail.com	www.facebook.com/rolpa.7
३	ग्रामस्त्री वृद्धाभ्यासिकरण परियोजना, समूह कार्यालय रोल्पा	नविन श्रेष्ठ	का.प्र.	०८६४४००६२	९८४७८२७९३७	शम्भु चौधरी शर्मा	९८४७८२७९३७	psamp.piu.rolpa@gmail.com	www.facebook.com/hakazone.rolpa
<b>बिना स्थित प्राविधिक शिालाहरू</b>									
१३	रोल्पा बहुविधिक शिक्षालय	वेज प्रसाद श्रेष्ठ	का.प्र.	०८६४४००६२	९८४७८२७९३७	पवन श्रेष्ठ	९८४७८२७९३७	rolpapolytechnicshilale@gmail.com	
<b>बिना स्थित संस्थागत कार्यालय, कार्यालयहरूको फोर्मेन नं., ईमेल ठेगाना र फेसबुक पेजको ठेगाना</b>									
१	नेपाल विद्युत प्राधिकरण, रोल्पा	शोभन श्रेष्ठ	का.प्र.	०८६४४००६२	९८४७८२७९३७	उज्वल सुब्बा	९८४७८२७९३७	nearolpa@yahoo.com	
२	नेपाल टेलिकम, रोल्पा	सुभाष श्रेष्ठ	का.प्र.	०८६४४००६२	९८४७८२७९३७	प्रकाश सुब्बा	९८४७८२७९३७	microolpa77035@gmail.com	
३	खाद्य व्यवस्था तथा व्यापार कम्पनी लिमिटेड	सुबोध श्रेष्ठ	का.प्र.	०८६४४००६२	९८४७८२७९३७	सुबोध श्रेष्ठ	९८४७८२७९३७	nrcrolpa@gmail.com	www.facebook.com/khadyasthisha.rolpa
४	साट ट्रेडिङ कर्पोरेशन लि. रोल्पा	बसन्त श्रेष्ठ			९८४७८२७९३७	बसन्त श्रेष्ठ	९८४७८२७९३७	strolpa@gmail.com	
<b>स्थायी तर्फ, तह प्रमुखको मोबाइल नं., ईमेल ठेगाना र फेसबुक पेजको ठेगाना</b>									
१	रोल्पा नगरपालिका, रोल्पा	राम प्रसाद शर्मा	प्र.प्र.अ.	०८६४४००६२	९८४७८२७९३७	शुशिला सुब्बा शर्मा	९८४७८२७९३७	rolpangarpalika@gmail.com	www.facebook.com/helrolpangarpalika.rolpa
२	सुदुरी गाउँपालिका, रोल्पा	बसन्त श्रेष्ठ	प्र.अ.	०८६४४००६२	९८४७८२७९३७	अमन श्रेष्ठ	९८४७८२७९३७	lunggramun@gmail.com	www.facebook.com/lunggramun
३	धवाङ गाउँपालिका, रोल्पा	हेमराज श्रेष्ठ	प्र.अ.	०८६४४००६२	९८४७८२७९३७	विमल सुब्बा	९८४७८२७९३७	thabangramun@gmail.com	www.facebook.com/thabangramun.municipal
४	त्रिवेणी गाउँपालिका, रोल्पा	विमल श्रेष्ठ	प्र.अ.	०८६४४००६२	९८४७८२७९३७	अमन श्रेष्ठ	९८४७८२७९३७	triveneenun@gmail.com	www.facebook.com/triveneenun.rolpa
५	समावेश गाउँपालिका, रोल्पा	आनन्द श्रेष्ठ	प्र.अ.	०८६४४००६२	९८४७८२७९३७	विमल श्रेष्ठ	९८४७८२७९३७	gangdevnun@gmail.com	www.facebook.com/gangdevnun.upalika
६	परिवर्तन गाउँपालिका, रोल्पा	विमल श्रेष्ठ	प्र.अ.	०८६४४००६२	९८४७८२७९३७	विमल श्रेष्ठ	९८४७८२७९३७	paribartarmun@gmail.com	www.facebook.com/paribartarmun
७	सुदुरी गाउँपालिका, रोल्पा	विमल श्रेष्ठ	प्र.अ.	०८६४४००६२	९८४७८२७९३७	विमल श्रेष्ठ	९८४७८२७९३७	ssminfo@gmail.com	
८	माडी गाउँपालिका, रोल्पा	विमल श्रेष्ठ	प्र.अ.	०८६४४००६२	९८४७८२७९३७	विमल श्रेष्ठ	९८४७८२७९३७	madl.rumun73@gmail.com	
९	सुदुरी गाउँपालिका, रोल्पा	विमल श्रेष्ठ	प्र.अ.	०८६४४००६२	९८४७८२७९३७	विमल श्रेष्ठ	९८४७८२७९३७	sunehabartarmun@gmail.com	
१०	रुद्राढी गाउँपालिका, रोल्पा	विमल श्रेष्ठ	प्र.अ.	०८६४४००६२	९८४७८२७९३७	विमल श्रेष्ठ	९८४७८२७९३७	rrmrolpa@gmail.com	

क्र. नं.	कार्यालयको नाम	कार्यालय प्रमुखको नाम र पद	पद	कार्यालयको सम्पर्क नं.	कार्यालय प्रमुखको नोवाइल नं.	सुचना अधिकारीको नाम	सुचना अधिकारीको नोवाइल नं.	कार्यालयको वेबसाइट ठेगाना	फैसलुक ठेगाना
	बिन्ला स्थित बैंक तथा बैंक प्रमुखहरूको संस्थाहरू नं., ईमेल ठेगाना र फेसबुक पेजको ठेगाना								
१	नेपाल बैंक लि., रोल्पा	विष्णु पाण्डे	प्र.	०८६४४०११४	९८४८०४८०१	विष्णु पाण्डे	९८४८०४८०३२	nblrolpa@nepalbank.com.np	
२	क्षेत्र विकास बैंक, रोल्पा	देव बहादुर बस्ती	प्र.	०८६४४०११७	९८४८०४८०३६	मोहन प्रसाद शर्मा	९८४८०४८०३९	rolpa.branch@adbl.gov.np	
३	स्वोचाल आरम्भ बैंक, रोल्पा	विमल कुमार शर्मा	प्र.	०८६४४०२८५	९८४८०४८०३३	टंकमान शर्मा	९८४८०४८०८०	hwang@grbl.com.np	
४	एन आई सी एसिया बैंक, रोल्पा	राधिका सुब्बा	प्र.	०८६४४०१०६	९८४८०४८०२४	राधिका सुब्बा		ayam.subeedi@nicsiabank.com	
५	प्रभु बैंक रोल्पा	सविता के.सी	प्र.	०८६४४०३११	९८४८०४८०३१	सविता के.सी		sabin.kc@prabhubank.com	
६	राष्ट्रिय वाणिज्य बैंक	प्रकाश कुमार मिश्र	प्र.	०८६४४०३०८	९८४८०४८०३३	रोल्पा चौधरी		rolpa.rtb.com.np	
	बिन्ला स्थित बैंक संस्थाको सम्पर्क नं.								
१	UNFPA	केदार शर्मा	प्र.		९८४८०३०७८१				
२	INF Rolpa	दिलक शर्मा	प्र.		९८४८०३४१०९			tiak.bhandari@nepal.inf.org	
३	रेडक्रस सोसाइटी बिन्ला शाखा रोल्पा	मौल सिंह कुमर	स.	०८६४४००३६	९८४८०४८०२७	मोहन शर्मा	९८४८०४८०३७	mcsrolpa@gmail.com	
४	रोल्पा उद्योग वाणिज्य संघ	केदार शर्मा	अ.	०८६४४०१६६	९८४८०४८०३००			rolpacamber166@gmail.com	
५	डिफेन्स नेपाल	देव बहादुर बस्ती	अ.		९८६६६६४४०४				
६	होरेक रोल्पा	सुभाष शर्मा	अ.						

**स्वास्थ्य कार्यालयबाट सम्पादन गरिएका कार्यक्रमका फलकहरू**





स्वास्थ्य कार्यालयबाट सम्पादन गरिएका कार्यक्रमका भलकहरू





स्वास्थ्य कार्यालयबाट सम्पादन गरिएका कार्यक्रमका भलकहरू



# स्वास्थ्य कार्यालयबाट सम्पादन गरिएका कार्यक्रमका भलकहरू



स्वास्थ्य कार्यालयबाट सम्पादन गरिएका कार्यक्रमका भलकहरू



स्वास्थ्य कार्यालयबाट सम्पादन गरिएका कार्यक्रमका भलकहरू



राल्पा अस्पताल



लुक्लिनी प्रदेश सरकार स्वास्थ्यसन्त्रालय स्वास्थ्य निर्देशनालय



बेरुजुको समिक्षा गोष्ठी तथा





**स्वास्थ्य कार्यालयबाट सम्पादन गरिएका कार्यक्रमका भलकहरू**





**स्वास्थ्य कार्यालय**  
**रोल्पा**

**सूचना अधिकारी**



**अरुण मितु उपाध्याय**

(अधिकृत तथ्याङ्क)

सम्पर्क नं.: ९८५७८७०१५

Email: rolpadho@gmail.com

कोठा नं. : ७



**स्वास्थ्य कार्यालय**  
**रोल्पा**

**गुनासो सुन्ने अधिकारी**



**जित बहादुर डांगी**

(ल्याब टेक्निसियन निरीक्षक)

सम्पर्क नं.: ९८५७८७५७३१

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कोठा नं. : ८



लुम्बिनी प्रदेश सरकार  
स्वास्थ्य मन्त्रालय  
स्वास्थ्य निर्देशनालय

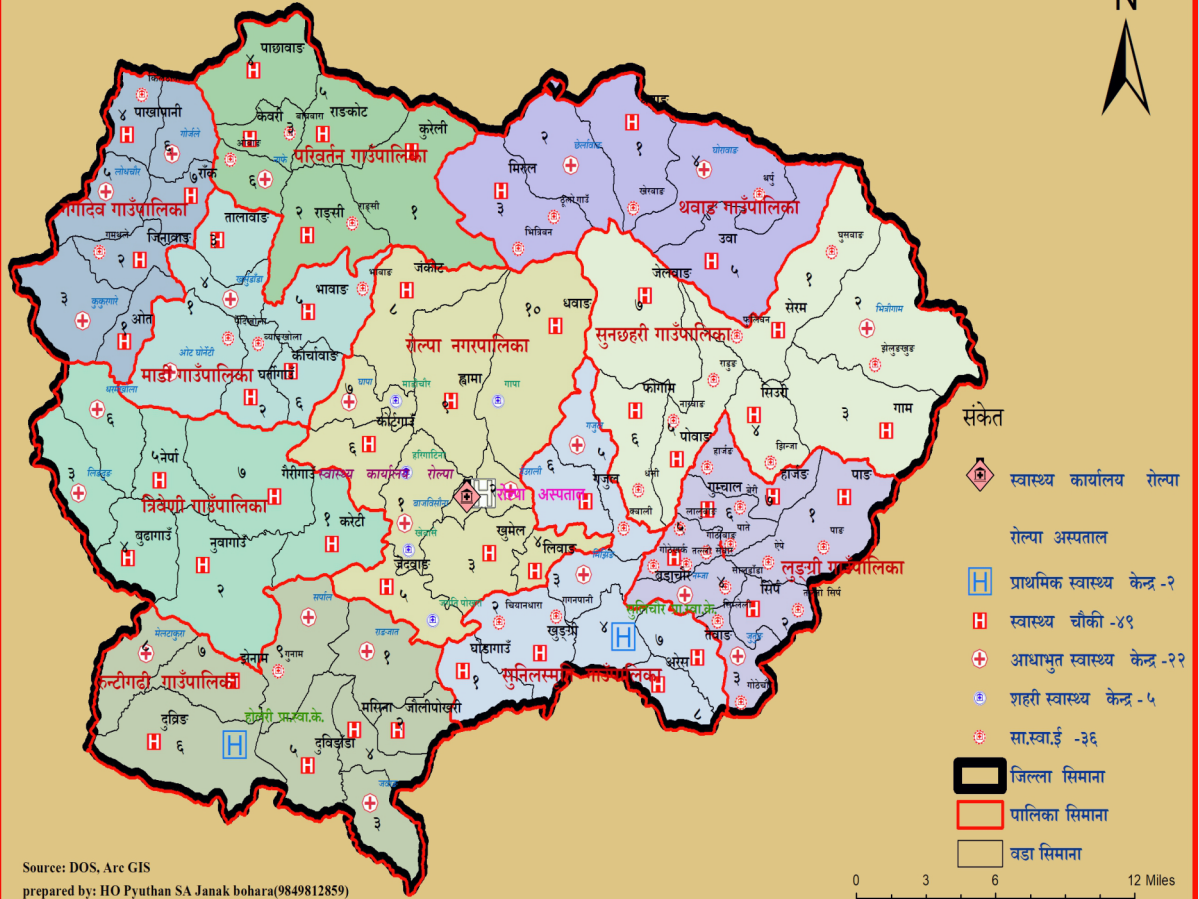
फोन ०८६-४९४०३३, ०८६-४९४०३४  
Email rolpadho@gmail.com  
रोल्पा न.पा.०२ रेजि. रोल्पा, नेपाल

स्वास्थ्य कार्यालय, रोल्पा  
नागरिक वडापत्र

क्र. सं.	सेवाको प्रकार	प्रक्रिया	सेवा प्राप्त गर्न लान्ने शुल्क/दस्तुर	समय	जिम्मेवार शाखा
१.	आन्तरिक प्रशासन सम्बन्धी कार्य (प्रशासनिक, व्यवस्थापन)	दर्ता चलानी/आन्तरिक प्रशासन	ऐन, नियममा तोकिए बमोजिम	कार्यालय समय	प्रशासन शाखा
२.	आर्थिक प्रशासन सम्बन्धी कार्य	ऐन, नियममा तोकिए बमोजिम	ऐन, नियममा तोकिए बमोजिम	कार्यालय समय	आर्थिक प्रशासन शाखा
३.	तालुक निकाय, जिल्लास्थित कार्यालयहरू र स्थानीय तहहरू बिच समन्वय	बैठक, कार्यशाला, गोष्ठी, अनुगमन, सुपरिवेक्षण	निःशुल्क	निरन्तर	कार्यालय प्रमुख तथा कार्यक्रमगत विभिन्न शाखा
४.	जनस्वास्थ्य तथा भेक्टर सर्भिलेन्स र विपद्/महामारी व्यवस्थापन	जानकारी भए पश्चात कर्मचारी उपलब्ध गराई रोकथाम तथा नियन्त्रण कार्यमा सहयोग गर्न सकिने	कार्य सञ्चालन निर्देशिकामा तोकिए बमोजिम	तुरुन्तै	महामारी/रोग नियन्त्रण तथा विपद् व्यवस्थापन शाखा र प्रयोगशाला शाखा
५.	जनस्वास्थ्य कार्यक्रम (बाल स्वास्थ्य, परिवार स्वास्थ्य, रोग नियन्त्रण, विशेषज्ञ स्वास्थ्य सेवा/शिविर आदि) सञ्चालन तथा सहयोग समन्वय र सहजीकरण गर्ने कार्य	कार्यक्रम सञ्चालन निर्देशिकामा उल्लेख भए बमोजिम	निःशुल्क	तोकिएको अवधिभित्र	कार्यक्रमगत विभिन्न शाखा
६.	समुदाय केन्द्रित स्वास्थ्य प्रवर्धन तथा जनस्वास्थ्य कार्यक्रमका राष्ट्रिय अभियान सञ्चालन सहजीकरण	कार्यक्रम सञ्चालन निर्देशिकामा उल्लेख भए बमोजिम	निःशुल्क	तोकिएको अवधिभित्र	कार्यक्रमगत विभिन्न शाखा
७.	तथ्याङ्क विश्लेषण, योजना तर्जुमा तथा पृष्ठपोषण	स्वास्थ्य सूचनाको विश्लेषण, अध्ययन गरी विभिन्न आबधिक समीक्षाबाट योजना तर्जुमा गर्न सकिने	निःशुल्क	निरन्तर	योजना, अनुगमन तथा तथ्याङ्क शाखा
८.	औषधी तथा खोप लगायत स्वास्थ्य सामग्रीहरूको भण्डारण/ वितरण	माग फाराम/हस्तान्तरण फाराम	निःशुल्क	तुरुन्तै	प्रशासन शाखा र बाल स्वास्थ्य, खोप तथा कोल्डचेन शाखा
९.	सरकारी, निजी र सहकारीद्वारा सञ्चालित स्वास्थ्य संस्थाहरूको गुणस्तर व्यवस्थापन सम्बन्धी कार्य	नियमित अनुगमन	निःशुल्क	निरन्तर	कार्यालय प्रमुख तथा कार्यक्रमगत विभिन्न शाखा
१०.	संस्थागत तथा जनशक्तिको प्राविधिक क्षमता अभिवृद्धि	स्थलगत अनुशिक्षण, तालिम, गोष्ठी, अनुगमन, सुपरिवेक्षण	निःशुल्क	निरन्तर	कार्यक्रमगत विभिन्न शाखा
११.	प्रयोगशाला सम्बन्धि जानकारी, खानेपानी तथा वातावरणीय गुणस्तर परिक्षण तथा अनुगमन	कार्यक्रम सञ्चालन निर्देशिकामा उल्लेख भए बमोजिम	निःशुल्क	निरन्तर	प्रयोगशाला शाखा एवम् कार्यक्रमगत विभिन्न शाखा
१२.	स्वास्थ्य शिक्षा, सूचना तथा सञ्चार	जनस्वास्थ्य समस्या रोकथाम तथा स्वास्थ्य प्रवर्धन सम्बन्धी सामग्रीहरू प्रकाशन, प्रसारण तथा अभियान सञ्चालन		निरन्तर	कार्यक्रमगत विभिन्न शाखा
१३.	सूचना प्रवाह	सूचनाको हक सम्बन्धी ऐन, २०६४ मा उल्लेख भए बमोजिम	ऐन, नियममा तोकिए बमोजिम	कार्यालय समय	सूचना अधिकारी
१४.	बहुभेदीय समन्वय सहजीकरण सम्बन्धी कार्यहरू	मौखिक वा लिखित		निरन्तर	कार्यालय प्रमुख तथा कार्यक्रमगत विभिन्न शाखा
१५.	स्वास्थ्य विमा कार्यक्रम सहजीकरण	ऐन, नियममा उल्लेख भए बमोजिम		निरन्तर	कार्यक्रमगत विभिन्न शाखा
१६.	निजि स्वास्थ्य संस्था/क्लिनिक/ पोलिक्लिनिक तथा अस्पतालहरू तथा एम्बुलेन्सहरूको संचालन अनुमती तथा नियमन	निर्देशिकामा उल्लेख भए बमोजिम	ऐन, नियममा तोकिए बमोजिम	निरन्तर	प्रशासन शाखा

\*राज्यका सबै तहमा स्वास्थ्य सेवाको पूर्वाधार: गुणस्तरीय र जनमुखी स्वास्थ्य सेवा; संवृद्धि एवम् दिगो विकासको आधार\*

# रोल्पा जिल्लाको सामाजिक नक्सा



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