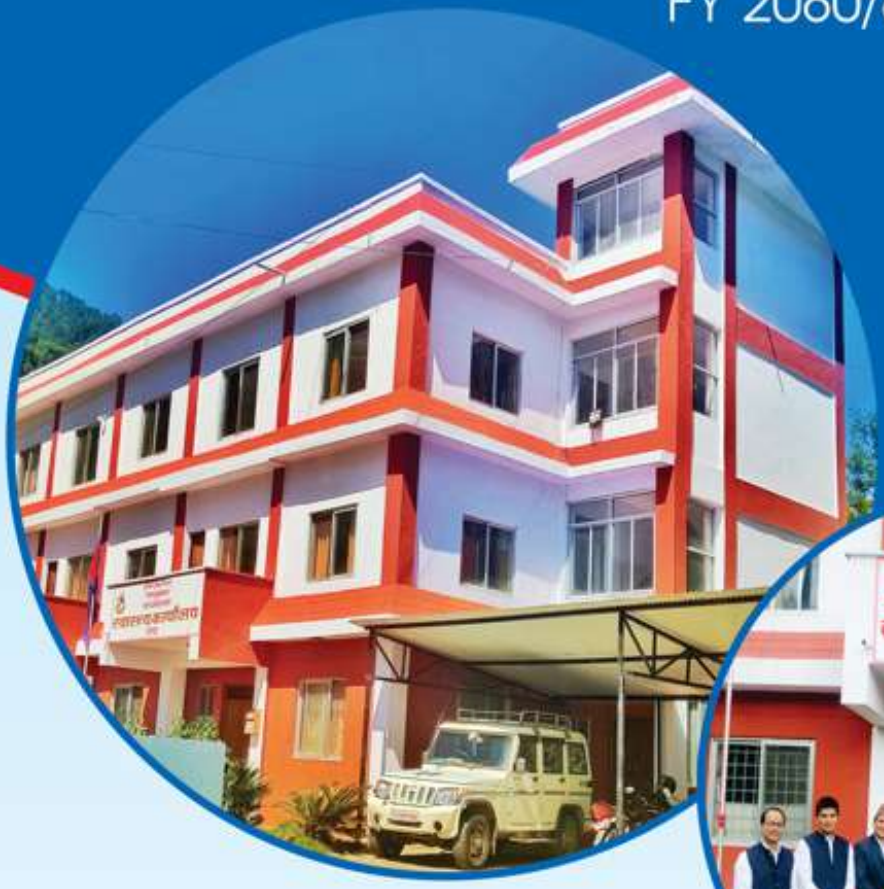
ANNUAL REPORT

FY 2080/81 (2023/24)



Lumbini Province Government

Ministry of Health

Health Directorate

Health Office, Rolpa

CHAPTER 1

INTRODUCTION

1.1. BACKGROUND

The Good Governance Act, 2008 specifies submission of annual progress report to higher authority. Based on that act Health Office, Rolpa (HO) has prepared annual health report, which is the fundamental part of Health Management Information System (HMIS). This report has been prepared after the completion of district level annual review meeting, followed by municipal level review meeting. It is the outcome of relevant information of annual performances of all the health programs and activities carried out during the FY 2080/81 through the network of health service outlets of Rolpa. It also analysis 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. 2078/79 to 2080/81. 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 seven annual health report of HO Rolpa after restructuring the health system based on federalization. This report includes information related to district health system, which can help in managing district health programs. With the organization and leadership of local level government, local level annual review workshop was conducted with full participation and involvement of HO staffs, municipal health workers and I/NGOs and others. Along with this, two days' district level review workshop was also conducted in the participation of HO team, line agencies, development partner and municipal health coordinators based on directives, norms and format set by Management Division (MD), DoHS and Ministry of Health (MoH) of Lumbini Province. Session-wise panal discussion was carried out with indicator-based presentations, discussions and review, analysis and recommendations of each program. Indicators and municipal's health facilities with satisfactory progress, good practices were appreciated and those with low performances were provided ways forward for improvement in coming days. Based on gap and indepth analysis of existing scenario of district health system, alltogether thirty-three points' recommendations and commitments were made for the improvements of overall public health system of district. *(See details in annex)*

This report covers the following areas:

- Overview of HO Rolpa
- Highlights of Major guiding policies like; National Health Policy 2076, Provincial Health Policy 2077, Constitutional provision in health, 16th Periodic Plan, SDG etc.
- Program specific information viz. background, targets, objectives, policies, strategies, trends analysis of service statistics
- Activities regarding the annual target vs. achievement, partners working with HO on various programs and,
- Program-specific issues, problems and constraints and recommendations etc

1.2. POLICIES AND PLANS

१. राष्ट्रिय स्वास्थ्य नीति २०७६

नेपालको संविधानले आधारभूत स्वास्थ्य सेवालाई प्रत्येक नागरिकको मौलिक हकको रुपमा स्थापित गरेको छ । देश संघीय शासन प्रणालीमा गई सकेकोले संघीय संरचनाको वस्तुगत धरातलमा आधारित रही गुणस्तरिय स्वास्थ्य सेवालाई सबै नागरिकको सर्वसुलभ पहुँचमा पुऱ्याउनु राज्यको दायित्व हो । संविधान बमोजिम राज्यका संघ, प्रदेश र स्थानीय तहले सम्पादन गर्ने कार्यहरुको एकल तथा साझा अधिकार सूची, नेपाल सरकारका नीति तथा कार्यक्रमहरु, नेपालले विभिन्न समयमा गरेका अन्तर्राष्ट्रिय प्रतिबद्धताहरु एवं स्वास्थ्य सेवा भित्रका समस्या र चुनौतीहरु, उपलब्ध श्रोत साधन तथा प्रमाणलाई समेत आधार बनाई राष्ट्रिय स्वास्थ्य नीति २०७६ तर्जुमा गरी जारी गरिएको छ ।

भावी सोच (Vision)

स्वस्थ तथा सुखी जीवन लक्षित सजग र सचेत नागरिक ।

ध्येय (Mission)

साधन श्रोतको अधिकतम एवं प्रभावकारी प्रयोग गरी सहकार्य र साझेदारी मार्फत नागरिकको स्वास्थ्य सम्बन्धी मौलिक अधिकार सुनिश्चित गर्ने ।

लक्ष्य (Goal)

संघीय संरचनामा सबै वर्गका नागिरककालागि सामाजिक न्याय र सुशासनमा आधारित स्वास्थ्य प्रणालीको विकास र विस्तार गर्दै गुणस्तरीय स्वास्थ्य सेवाको पहुँच र उपभोग सुनिश्चित गर्ने ।

उद्धेश्यहरु (Objectives)

१। संविधान प्रदत स्वास्थ्य सम्बन्धी हक सबै नागरिकको उपभोग गर्न पाउने अवसर सिर्जना गर्नु ।

२। संघीय संरचना अनुसार सबै किसिमका स्वास्थ्य प्रणालीलाई विकास, विस्तार र सुधार गर्नु ।

३। सबै तहका स्वास्थ्य संस्थाहरुबाट प्रदान गरिने सेवाको गुणस्तरमा सुधार गर्दै सहज पहुँच सुनिश्चित गर्नु ।

४। अति सिमान्तकृत वर्गलाई समेट्दै सामाजिक स्वास्थ्य सुरक्षा पद्धतिलाई सुदृढ गर्नु ।

५। सरकारी, गैरसरकारी तथा नीजि क्षेत्रसँग बहुक्षेत्रीय साझेदारी, सहकार्य तथा सामुदायिक सहभागितालाई प्रबर्धन गर्नु ।

६। नफामूलक स्वास्थ्य क्षेत्रलाई सेवामूलक स्वास्थ्य सेवामा रुपान्तरण गर्दै जानु ।

नीतिहरु :

१। सबै तहका स्वास्थ्य संस्थाहरुबाट तोकिएबमोजिम निःशुल्क आधारभूत स्वास्थ्य सेवा सुनिश्चित गरिनेछ ।

२। स्वास्थ्य बिमामार्फत विशेषज्ञ सेवाको सुलभ पहुँच सुनिश्चित गरिनेछ ।

३। सबै नागरिकलाई आधारभूत आकस्मिक स्वास्थ्य सेवाको पहुँच सुनिश्चित गरिनेछ ।

४। स्वास्थ्य प्रणालीलाई संघीय संरचनाअनुरुप संघ, प्रदेश र स्थानीयतहमा पुर्नसंरचना, सुधार एवं विकास तथा विस्तार गरिनेछ ।

५। स्वास्थ्यमा सर्वव्यापी पहुँच (Universal Health Coverage) को अवधारणा अनुरुप प्रवर्धनात्मक, प्रतिकारात्मक, उपचारात्मक, पुनस्थापनात्मक तथा प्रशामक सेवालाई एकिकृत रुपमा विकास तथा विस्तार गरिनेछ ।

६। स्वास्थ्य क्षेत्रमा सरकारी, नीति तथा गैर सरकारी क्षेत्र बीचको सहकार्य तथा साझेदारीलाई प्रबर्द्धन, व्यवस्थापन तथा नियमन गर्नुका साथै स्वास्थ्य शिक्षा, सेवा र अनुसन्धानका क्षेत्रमा नीजि, आन्तरिक तथा बाह्य लगानीलाई प्रोत्साहन एवं संरक्षण गरिनेछ ।

७। आयुर्वेद, प्राकृतिक चिकित्सक, योग तथा होमियोप्याथिक लगायतका चिकित्सा प्रणालीलाई एकीकृत रुपमा विकास र विस्तार गरिनेछ ।

८। स्वास्थ्य सेवालाई सर्वसुलभ, प्रभावकारी तथा गुणस्तरीय बनाउन जनसंख्या, भूगोल र संघीय संरचना अनुरुप सीप मिश्रित दक्ष स्वास्थ्य जनशक्तिको विकास तथा विस्तार गर्दै स्वास्थ्य सेवालाई व्यवस्थित गरिनेछ ।

९। सेवा प्रदायक व्यक्ति तथा संस्थाबाट प्रदान गरिने स्वास्थ्य सेवालाई प्रभावकारी, जवाफदेही र गुणस्तरीय बनाउन स्वास्थ्य व्यवसायी परिषद्हरुको संरचनाको विकास, विस्तार तथा सुधार गरिनेछ ।

१०। गुणस्तरीय औषधि तथा प्रविधिजन्य स्वास्थ्य सामाग्रीको आन्तरिक उत्पादनलाई प्रोत्साहन गर्दै कुशल उत्पादन, आपूर्ति भण्डारण, वितरणलाई नियमन तथा प्रभावकारी व्यवस्थापन मार्फत पहुँच एवं समुचित प्रयोग सुनिश्चित गरिनेछ ।

११। सरुवा रोग, किटजन्य रोग, पशुपन्छीजन्य रोग, जलवायु परिवर्तन र अन्य रोग तथा महामारी नियन्त्रण लगायत विपद् व्यवस्थापन पूर्व तयारी तथा प्रतिकार्यको एकीकृत उपायहरु अवलम्बन गरिनेछ ।

१२। नसर्ने रोगहरुको रोकथाम तथा नियन्त्रणका लागि व्यक्ति, परिवार समाज तथा सम्बन्धित निकायलाई जिम्मेवार बनाउँदै एकीकृत स्वास्थ्य प्रणालीको विकास तथा विस्तार गरिनेछ ।

१३। पोषणको अवस्थालाई सुधार गर्न, मिसावटयुक्त तथा हानिकारक खानालाई निरुत्साहित गर्दै गुणस्तरिय एवं स्वास्थ्यवर्धक खाद्य पदार्थको प्रबर्द्धन, उत्पादन, प्रयोग र पहुँचलाई विस्तार गरिनेछ ।

१४। स्वास्थ्य अनुसन्धानलाई अन्तर्राष्ट्रिय मापदण्ड अनुरुप गुणस्तरिय बनाउँदै अनुसन्धानबाट प्राप्त प्रमाण र तथ्यहरुलाई नीति निर्माण, योजना तर्जुमा तथा स्वास्थ्य पद्धतिको विकासमा प्रभावकारी उपयोग गरिनेछ ।

१५। स्वास्थ्य व्यवस्थापन सूचना प्रणालीलाई आधुनिकिकरण, गुणस्तरिय तथा प्रविधिमैत्री बनाई एकीकृत स्वास्थ्य सूचना प्रणालीको विकास गरिनेछ ।

१६। स्वास्थ्य सम्बन्धी सूचनाको हक तथा सेवाग्राहीले उपचार सम्बन्धी जानकारी पाउनेहकको प्रत्याभूति गरिनेछ ।

१७। मानसिक स्वास्थ्य, मुख, आँखा, नाक कान घाँटी स्वास्थ्य सेवा लगायतका उपचार सेवालाई विकास र विस्तार गरिनेछ ।

१८। अस्पताल लगायत सबै प्रकारका स्वास्थ्य संस्थाबाट प्रदान गरिने सेवाको गुणस्तर सुनिश्चित गरिनेछ ।

१९। स्वास्थ्य क्षेत्रमा नीतिगत, संगठनात्मक तथा व्यवस्थापकीय संरचनामा समयानुकूल परिमार्जन तथा सुधार गर्दै सुशासन कायम गरिनेछ ।

२०। जीवनपक्षको अवधारणा अनुरुप सुरक्षित मातृत्व, बाल स्वास्थ्य, किशोर किशोरी तथा प्रजनन स्वास्थ्य, प्रौढ तथा जेष्ठ नागरिक लगायतका सेवाको विकास तथा विस्तार गरिनेछ ।

२१। स्वास्थ्य क्षेत्रको दिगो विकासकालागि आवश्यक वित्तिय श्रोत तथा विशेष कोषको व्यवस्था गरिनेछ ।

२२। बढ्दो शहरीकरण, आन्तरिक तथा बाह्य बसाईसराई जस्ता विषयहरुको समयानुकूल व्यवस्थापन गर्दै यसबाट हुने जनस्वास्थ्य सम्बन्धी समस्याहरुलाई समाधान गरिनेछ ।

२३। जनसांख्यिक तथ्यांक व्यवस्थापन, अनुसन्धान तथा विश्लेषण गरी निर्णय प्रक्रिया तथा कार्यक्रम तर्जुमासँग आबद्ध गरिनेछ ।

२४। प्रति जैविक प्रतिरोधलाई न्यूनिकरण गर्दै संक्रामक रोग नियन्त्रण तथा व्यवस्थापनकालागि एकद्धार स्वास्थ्य प्रद्धतिको विकास तथा विस्तार गरिनुका साथै वायु प्रदुषण, ध्वनि प्रदुषण, जल प्रदुषण लगायतका वातावरणीय प्रदुषणका साथै खाद्यान्न प्रदुषणलाई वैज्ञानिक ढँगले नियमन तथा नियन्त्रण गरिनेछ ।

२५। आप्रवासन, प्रक्रियाबाट जनस्वास्थ्यमा उत्पन्न हुन सक्ने जोखिमलाई न्यूनिकरण गर्न तथा विदेशमा रहेका नेपाली नागरिकहरुको स्वास्थ्य सुरक्षाका लागि समुचित व्यवस्थापन गरिनेछ ।

२.प्रदेश स्वास्थ्य नीति, २०७७ (लुम्बिनी प्रदेश)

नेपालको संविधानले निःशुल्क आधारभूत तथा आकस्मिक स्वास्थ्य सेवालाई मौलिक हकको रुपमा स्थापित गरेको छ। देश संघीय शासन प्रणालीमा रुपान्तरण 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 कार्यहरुको अधिकार सूची, संघीय नीति तथा कार्यक्रमहरु, दिगो विकास लक्ष्य, नेपालले विभिन्न समयमा गरेका अन्तर्राष्ट्रिय प्रतिबद्धताहरु एवम

प्रदेशमा स्वास्थ्य क्षेत्र भित्रका समस्या र चुनौतीहरु, प्रदेश नीति, प्रदेशमा उपलब्ध साधन र स्रोत, तथ्य तथा प्रमाणहरुलाई समेत विश्लेषण गरी प्रदेशको स्वास्थ्य नीतिका प्राथमिकता तय गरिएको छ। यसैको आधारमा प्रदेशको समृद्धकालागि समृद्द प्रदेश खुसी जनता भन्ने दीर्घकालीन सोचलाई सार्थक तुल्याउन प्रदेश स्वास्थ्य नीति, २०७७ तर्जुमा गरी जारी गरिएको छ।

भावी सोच (Vision)

समृद्ध प्रदेशका लागि स्वस्थ र खुसी नागरिक ।

ध्येय (Mission)

प्रदेशबासीको स्वस्थ रहन पाउने मौलिक हकको सुनिश्चितता गर्ने ।

लक्ष्य (Goal)

समतामूलक एवम् सुदृढ स्वास्थ्य सेवा प्रणालीको माध्यमबाट गुणस्तरीय स्वास्थ्य सेवामा सबैको पहुँच वृद्धिगरि प्रदेशबासीको स्वास्थ्य अवस्थामा उच्चतम सुधार ल्याउने ।

उद्देश्यहरू (Objectives)

१। सबै तहमा आवश्यक सेवा तथा पुर्वाधार, औषधि, औजार तथा उपकरण, सूचना, प्रविधि र दक्ष स्वास्थ्यकर्मीहरू सहितको सक्षम र प्रभावकारी स्वास्थ्य सेवा प्रर्णाली सुनिश्चित गर्नु ।

२। आर्थिक, सामाजिक तथा भौगोलिक रुपमा पिछडिएका लगायत सबै प्रदेशबासीले सबै तहबाट सहज, सुलभ, सरल र गुणर्स्तरीय स्वास्थ्य सेवा प्राप्त गर्न सक्ने गरि सेवाको पहुँच अभिबृद्धि गर्नु

३। स्वस्थ जीवनशैली प्रवद्धन, व्यवहार परिवर्तन र स्वास्थ्यमा प्रतिकूल असर गर्ने कारक तत्वहरुलाई निरुत्साहित गर्नकालागि अनुकूल वातावरण सिर्जना गर्नु ।

४। आपतकालीन र विपद्को अवस्थामा स्वास्थ्य सेवा प्रवाह प्रभावकारी रुपमा अविच्छिन्न उपलब्ध गराउनु ।

५। स्वास्थ्य सेवा व्यवस्थापनमा अन्तर सरकारी, सामुदायिक तथा बहुपक्षीय समन्वय, साझेदारी र सहकार्य गर्ने साथै आवश्यकता अनुरुप निजी र गैरसरकारी क्षेत्रसँग समेत सहकार्य गर्नु ।

६। सुशासन, जवाफदेहिता र जिम्मेवारीपनको प्रबद्धन गरि स्वास्थ्य सेवालाई जनउत्तरदायी बनाउनु।

७। स्वास्थ्य क्षेत्रमा लगानी बृद्धि 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 नागरिकहरुको 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 गरिने छ।

२.विशेषज्ञ तथा विशिष्टीकृत स्वास्थ्य सेवालाई 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 पद्धतिहरुको आधारभूत, विशेषज्ञ तथा विशिष्टीकृत स्वास्थ्य सेवा प्रभावकारी रुपमा उपलब्धगराइने छ।

६.न्यूनतम सेवा मापदण्ड (Minimum Service Standard) तथा राष्ट्रिय चिकित्सा मापदण्ड (National Medical Standard) का आधारमा प्रादेशिक मापदण्ड तयार गरि स्वास्थ्य संस्थाहरुबाट गुणस्तरीय रुपमा 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 रोगहरुको रोकथाम तथा व्यवस्थापनको लागि प्रर्बधनात्मक,प्रतिकारात्मक, उपचारात्मक, पुर्नस्थापनात्मक तथा प्रशामक (Palliative) स्वास्थ्य सेवा प्रवाह गरिने छ।

१०.स्वस्थ सकारात्मक व्यवहार परिवर्तनका लागि स्वास्थ्य शिक्षा रसूचना प्रवाह गदै अनुकूल वातावरण सुनिश्चित गरिने छ ।

११.बढ्दो शहरीकरणबाट उत्पन्न हुने स्वास्थ्य समस्याहरुको व्यवस्थापनको लागि शहरी स्वास्थ्य प्रर्बद्धन योजना तर्जुमा गरि कार्यान्वयन गरिने छ।

१२.स्वास्थ्य बर्धक खाद्य प्रदार्थको प्रर्बद्धन र उपभोग बढाई पोषण स्थितिमा सुधार गरिने छ र उत्पादन तथा पहुँचमा वृद्धि गर्न आवश्यक समन्वय गरिने छ।

१३.विपद् वा प्रकोपको समयमा पर्न सक्ने सम्भवत स्वास्थ्य असरहरु तथा महामारी न्यूनीकरण एवम प्रतिकार्यको लागि बहुपक्षीय सहकार्य गरिने छ।

१४.वातावरणबाट स्वास्थ्यमा पर्ने प्रतिकूल असरहरु न्यूनीकरण तथा व्यवस्थापन गरिने छ।

१५.स्वास्थ्य क्षेत्रका प्रगती एवम उपलब्धीहरुलाई संस्थागत गर्दै थप उपलब्धी हासिल गर्न आवश्यक समन्वय र सहकार्य गरिने छ।

१६.विभिन्न कार्यस्थलहरुमा काम गर्ने कामदारहरुको पेशागत स्वास्थ्य सुरक्षा सुनिश्चित गरिने छ

१७.स्वास्थ्य सेवाको पहुँच र उपयोगमा वृद्धि गर्न सार्वजनिक, सामुदायिक तथा आवश्यकता अनुसार नीजी क्षेत्रसँग साझेदारी गरिने छ।

१८.अध्ययन तथा अनुसन्धानात्मक कार्यलाई प्रबद्धन गदै 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 गदै स्वास्थ्य सेवालाई जनमुखी एवम परिमाणमूखी बनाईने छ।

२१.सरुवा रोग, किटजन्य रोग, पशुपन्छीजन्य रोग एवम सिकल सेल एनेमिया,थालासेमिया जस्ता निश्चित स्थान र समुदायमा विद्यमान रोगहरु तथा खुला सिमानाबाट भित्रिन सक्ने रोगहरुको रोकथाम, नियन्त्रण तथा व्यवस्थापन प्रभावकारी रुपमा 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 प्रदेशभित्र स्वास्थ्य पर्यटनको प्रबद्धन गरिने छ।

२४.जनसांख्यिक स्थिति र वितरणको आधारमा स्वास्थ्य सेवा कार्यक्रम तर्जुमा गरि कार्यन्वयन गरिने छ।

३। नेपालको संविधान २०७२ मा स्वास्थ्यः

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 महिलाको हक अन्तर्गत उपधारा २ मा "प्रत्येक महिलालाई सुरक्षित मातृत्व र प्रजनन स्वास्थ्य सम्बन्धी हक हुनेछ ।" भन्ने कुरा उल्लेख छ ।

त्यस्तै धारा ५१ मा उल्लेखित राज्यका नीतिहरू अर्न्तगत स्वास्थ्यसम्बन्धी 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 परम्परागत चिकित्सा पद्धतिको रूपमा रहेको आयुर्वेदिक, प्राकृतिक चिकित्सा र होमियोपेथिक लगायत स्वास्थ्य पद्धतिको संरक्षण र प्रवर्धन गर्ने,

(८) स्वास्थ्य क्षेत्रमा राज्यको लगानी अभिवृद्धि गर्दै यस क्षेत्रमा भएको निजी लगानीलाई नियमन र व्यवस्थापन गरी सेवामूलक बनाउने,

(९) स्वास्थ्य सेवालाई सर्वसुलभ र गुणस्तरीय बनाउन स्वास्थ्य अनुसन्धानमा जोड दिदै स्वास्थ्य संस्था र स्वास्थ्यकर्मीको संख्या वृद्धि गर्दै जाने,

(१०) नेपालको क्षमता र आवश्यकताका आधारमा जनसंख्या व्यवस्थापनकालागि परिवार नियोजनलाई प्रोत्साहित गर्दै मातृ शिशु मृत्युदर घटाई औसत आयु बढाउने ।

स्थानीय तहको स्वास्थ्य सम्बन्धि अधिकार तथा कार्य विस्तृतीकरण

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अनुसूची	अधिकार सूचीको क्र.सं	संविधानको अधिकार सूचीका विषयको विस्तृतीकरण
अनुसूची ८(९) आधारभूत स्वास्थ्य र सरसफाइ	९.१	आधारभूत स्वास्थ्य र सरसफाइ सम्बन्धी नीति, कानुन, 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 खाद्य पदार्थको गुणस्तर एवं वायु तथा ध्वनि प्रदुषण 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	औषधी पसल सञ्चालन र नियमन

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अनुसूची	अधिकार सूचीको क्र.सं	संविधानको अधिकार सूचीका विषयको 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 अनुरुप 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 बिमा लगायतका सामाजिक सुरक्षा कार्यक्रम व्यवस्थापन
	३.६	स्थानीय स्तरमा औषधी तथा अन्य मेडिकल उत्पादनहरुको न्यूनतम मूल्य निर्धारण तथा नियमन
	३.७	स्थानीय स्तरमा औषधीको उचित प्रयोग र सूक्ष्म जीव निरोधक प्रतिरोध (Antimicrobial Resistance)न्यूनीकरण
	३.८	स्थानीय स्तरमा औषधी र स्वास्थ्य उपकरणको खरिद, भण्डारण र वितरण
	३.९	स्थानीय स्तरमा स्वास्थ्य सूचना प्रणली व्यवस्थापन

४। राष्ट्रिय जनसंख्या नीति, २०७१

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

राष्ट्रिय जनसंख्या नीतिको भावी सोच, ध्येय, लक्ष्य तथा उद्देश्यहरु देहाय बमोजिम 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 सेवा प्रवाहको 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	लक्षित वर्ष वि.सं.(२०३४) (सन् २०९०)
१	कुलप्रजननन्दर (TFR), प्रति महिला	2.1
२	वार्षिक जनसंख्या वृद्धिदर, प्रतिशत	1.1
३	कोरा मृत्युदर (CDR), प्रतिहजार	5.0
४	शिशु मृत्युदर (IMR), प्रति हजार जीवितजन्म	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 वर्ष माथिको जनसंख्या)	95.0
९	परिवार नियोजन साधनमा पहुँचहुने सम्भाव्य दम्पती प्रतिशत	90.0
१०	सहरी जनसंख्या, प्रतिशत	60.0

उद्देश्यहरु :

१। जनसंख्या र विकास बीच तादाम्य कायम गरी जनसंख्या व्यवस्थापनलाई समग्र विकासको अभिन्न अंगका रुपमा विकास गर्ने,

२। यौन र प्रजनन स्वास्थ्य, परिवार नियोजन जस्ता सेवाहरुलाई अधिकारमुखी कार्यक्रमका रुपमा विकास गर्ने,

३। स्वस्थ जीवनयापनकालागि स्वास्थ्य सेवा प्रवाहलाई गुणस्तरीय बनाउने,

४। वाह्य तथा आन्तरीक बसाईसराई र सहरीकरणलाई व्यवस्थित गर्ने,

५। लैंगिक समानता तथा सामाजिक समावेशीकरणलाई विकासका सबै आयामहरुमा समाहित गर्ने,

६। जनसाङ्ख्यिक तथ्यांक व्यवस्थापन, अध्ययन, अनुसन्धान, सर्वेक्षण र विश्लेषण गर्ने कार्यलाई व्यवस्थित र प्रभावकारी बनाउने र

७। राष्ट्रिय उत्पादकत्व वृद्धिका लागि सक्रिय जनसंख्यालाई उत्पादनशील र उद्योगमुखी बनाउने ।

नीतिहरु :

१। जनसंख्या र विकास बीच तादाम्य कायम गर्न जनसंख्या व्यवस्थापनलाई समग्र विकासको अभिन्न अंगका रुपमा लिँदै सरोकारवाला निकायका बीचमा सम्पर्क र समन्वय स्थापित गरिने छ ।

२। यौन स्वास्थ्य, परिवार नियोजन र सुरक्षित गर्भपतन लगायतका प्रजनन स्वास्थ्य सेवालाई अधिकारमुखी कार्यक्रमका रुपमा विकास गरिने छ ।

३। स्वस्थ जीवनयापनका लागि उपयुक्त जीवन शैली एवं वातावरणको निर्माण गरिने छ ।

४। बाह्य तथा आन्तरकि बसाईसराई र सहरीकरणको प्रभावकारी व्यवस्थापन गरिने छ ।

५। लैगिक, यौनिक, भाषिक, आर्थिक, सामाजिक एवं क्षेत्रीय रुपमा पछि परेका समूह र शारीरिक, मानसिक तथा बौद्धिक रुपमा आपाङ्गता भएका व्यक्तिहरुलाई समावेशीकरण गर्दै जनसंख्या र विकासमा मुलप्रवाहीकरण गर्न नीति, कानुन तथा संस्थागत व्यवस्थामा सुधार गरिने छ ।

६। जनसंख्या क्षेत्रका नीति निर्माण, कार्यक्रम तर्जुमा, कार्यान्वयन, अनुगमन र मुल्यांकनकालागि संस्थागत संरचनाको सुदृढीकरण गरिने छ ।

७। जनसंख्या तथा विकास बीचको अन्तर सम्बन्धको सूचना प्रविधि समेतका उपयोगबाट अध्ययन, अनुसन्धान र विश्लेषण गरी नीति निर्माण र कार्यक्रम तर्जुमाकालागि सरोकारवाला निकायहरुलाई पृष्ठपोषण गरिने छ ।

८। विकास आयोजना र कार्यक्रम तर्जुमा गर्दा तिनको जनसाङ्ख्यिक प्रभावको समेत अध्ययन गरी तिनको उपयुक्तता पुष्टि गरेर मात्र कार्यक्रम कार्यान्वयन गरिने छ ।

९। जनसंख्याको लाभांश (Demogrphic Dividend) हुने हिस्सा र खास गरी युवा समूहलाई रोजगार मूलक कार्यमा उपयोग गरिने छ ।

५। सोह्रौं योजना (आर्थिक वर्षः 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 स्वस्थ्य 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 समेटी 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 वच्चाहरूको लागि पोषण र स्वस्थ्य वातावरण प्रदान गर्दछन्। जनसङ्ख्याको स्वास्थ्य स्थितिले दीर्घकालीन आर्थिक समृद्धि र सामाजिक-आर्थिक रूपान्तरणमा महत्त्वपूर्ण 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 जनसाङ्ख्यिक लाभ लिने गरी आवश्यक मानव पुँजी निर्माण गर्न थप लगानी गर्नुपर्ने अवस्था छ। मानव पुँजी निर्माणमा सङ्घ, प्रदेश र स्थानीय तहको भूमिका र जिम्मेवारीलाई प्रभावकारी रूपमा निर्वाह गर्न समन्वय र साझेदारीलाई महत्त्व 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 प्रदेशस्तरसम्म 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 तथा एकीकृत ,भरपर्दो ,स्वास्थ्य प्रणालीको विकास गर्ने
(६) स्वास्थ्य पर्यटन प्रवर्द्धन गर्ने
(७) बहुक्षेत्रीय र बहुपक्षीय अवधारणा अवलम्बन गर्ने

(८) जनसाङ्ख्यिक लाभांशको अधिकतम उपयोग गर्ने

(९) अध्ययनअनुसन्धान तथा तथ्यमा आधारित स्वास्थ्य व ,्यवस्थापन 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 कार्यक्रमः 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) विशिष्टिकृत 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 प्रजनन् 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)सरकारीसामुदायिक 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 लक्ष

क्र.सं.	सूचक	एकाइ	आ.व. २०७९/८०	आ.व. २०८५/८६
(क) स्वास्थ्य				
१	मातृ मृत्यु दर (प्रति लाख जीवित जन्ममा)	जना	१५१	८५
२	नवजात शिशु मृत्यु दर (प्रति हजार जीवित जन्म)	जना	२१	१३

३	पाँच बर्षमुनिका बालबालिकाको मृत्यु दर (प्रति हजार जीवित जन्ममा)	जना	३३	२२
४	पाँच बर्षमुनिका बालबालिकाको पुड्कोपनाको अवस्था	प्रतिशत	२५	१७
५	सडक दुर्घटनाका कारण ज्यान गुमाउने व्यक्तिको सङ्ख्या (प्रति एक लाख जनसङ्ख्यामा)	जना	९.५	५
६	पूर्ण खोप पाउने बालबालिका	प्रतिशत	८०	९५
७	स्वास्थ्यकर्मी उत्पादन (प्रति हजार जनसङ्ख्यामा)	जना	१.९४	४.६४
८	स्वास्थ्य बीमामा आबद्द 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 बर्षमुनिका बच्चाहरु मध्ये जन्म दर्ता गरिएको बालबालिका	प्रतिशत	७४	१००

श्रोतः सोहौं योजना(आ.व. २०८१/८२-२०८५/८६)

6. Sustainable Development Goals

The Sustainable Development Goals (SDGs), officially known as Transforming our world: the 2030 Agenda for Sustainable Development is a set of seventeen aspirational "Global Goals" with 169 targets, between them Sustainable Development Goal 3 is among the most specific SDGs with a number of clear, measurable targets. It is a direct result of the fact that Goal 3 can build on experiences with the Millennium Development Goals (MDGs), which had a very strong 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 on SDG Indicators (IAEG-SDGs) suggests repeatedly disaggregating data by geographic location (e.g. urban and rural) but also by age group, sex and income as data systems improve. Furthermore, a simple adoption of global targets at the national level is highly disadvantageous to countries with bad starting conditions (William Easterly's article "How the Millennium Development Goals Are Unfair to Africa" from 2009 is a prominent source in this regard).

The SDG3 isoperationalized through nine targets and four suggestions for means of implementation. Most of the targets deal with health issues that are relevant for developing and developed countries alike. Most of the targets are very precise; the levels of ambition, however, vary considerably between the targets.

Targets:

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

Target 3.2: The target requires 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 to "strengthen prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol".

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

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

Target 3.8: The target requires to "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 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 on healthy lives and well-being, instead of the mere absence of disease or infirmity, 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 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 of poor countries to receive external support.

7. First Five-Year Plan (2076/77-2080/81-Lumbini Province)

The First Five-Year Plan of Provincial Planning Commission is developed based on the Constitution of Nepal, National Long-term Vision 2100, 15th Plan, Sustainable Development

Goals and policies and program of province government and set to achieve "prosperous province: Happy citizen". In the health sector, the plan envisions to develop healthy and strong citizen by providing access to quality healthcare for all. The goal, objectives, strategies and expected outcomes set by the plan in health sector mentioned hereunder:

Goal:

- Provide quality health services to all citizens easily

Objectives:

- Ensure equitable access to basic health services
- Make easy access of people to quality promotive, preventive and curative services
- Minimize risk factors in the field of public health promotion

Strategies:

- Expand access to basic health services and improve qualitatively
- Increase the capacity of hospitals, including quality curative services, and provide specialized health services at province
- Adopt and promote alternative methods of health treatment
- Conduct public awareness campaign related to health
- Arrange for the availability of quality and nutritious food in the market

Expected outcomes:

- Achieved health-related sustainable development goals through increasing easy access to health services
- Established Trauma center and Provided specialized health services through provincial hospitals

1.3. OVERVIEW OF ROLPA DISTRICT

With the implementation of federal structure in Nepal, Rolpa district is located in Lumbini Province, it is a hilly district divided in to ten local levels i.e. one Municipality (Rolpa) and 9 Rural municipalities (Sunilsmriti, Lungri, Sunchhahari, Thabang, Paribartan, Madi, Sukidaha, Tribeni and Runtigadhi). Famous tourism places with in 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, Chunaare Bhir etc. Major market areas of the district are Liwang, Sulichour, Ruinibang, Holieri, Ghartigaun, Khungri, Baghmara, Thabang, Madichour etc. There are two popular rivers named as Madi and Lungri which flowing from west and east of the district respectively.

Before the 15th century, the Rukumkot's (Rukum District) King ruled over the Rolpa District area. Tuthansen (King of Salyankot) established a separate kingdom carving out some 18 villages from Rukumkot's Kingdom, which is given to him as dowry by Jayanta Berma (King of Rukumkot) and was named Gajulkot. Rolpa district was part of two different districts Pyuthan and Salyan established in 1962 during Rana regime.

Basic Socio-Demographic Information

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 Anuual Growth Rate	10287	0.43
Avarage Household Size	4.50	NA
Total Litetacy Rate	-	75.6
Litetacy Rate (Male)	-	84.0%
Litetacy Rate (Female)	-	68.4%
Economically Active Population (> 10 years)	127009	68.1%
Population Density (per Sq. KM)	125	NA
Sex Ratio (male per 100 female)	NA	87.95
Human development Index Rank	-	0.395
Life expectancy rate (Years)	-	66.28
Population with disability	8923	3.8%
Election Contituent (Federal/Province)	1/2	-
Total no. Municipalities	1	-
Total no. of Rural Municipalities	9	-
Total no. of Wards	72	-
		Source: Census 2021

Municipal Level Basic Information

Municiplality Name	Total Area (Sq. KM)	Total Wards	Households	Population		
				Total	Male	Female
Thawang R/M	191	5	2551	10851	5110	5741
Paribartan R/M	163	6	4685	21671	9985	11686
Madi R/M	130	6	4136	18056	8421	9635
Gangadev R/M	124	7	4433	21503	10045	11458
Sunchhahari R/M	278	7	3585	17241	8290	8951
Tribeni R/M	205	7	5357	23412	11024	12388
Lungri R/M	129	7	5489	26825	12585	14240
Sunilsmirti R/M	157	8	7015	31117	14504	16613
Runtigadi R/M	233	9	6224	28291	13349	14942
Rolpa M/P	270	10	8746	35826	16558	19268
Total	**1880**	**72**	**52221**	**234793**	**109871**	**124922**
						Source: Census 2021

Geographical and Political Information

Latitue :$83^0$10" to $83^0$90' east latitude
Longitude :$28^0$38" to $28^0$80" north longitude
Total Area : 1879 Sq. Km
Length (East-West) : 67 Km
Breadth (Notth-South): 28.04 Km

Map of Rolpa District

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 : 32.5^0C
Minimum : 11.8^0C
District Headquartar: Liwang

1.4. HEALTH OFFICE STRUCTURE AND SYSTEMS

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 is also giving priority to strengthening district health system (DHS) in order to improve Primary Health Care Service Delivery. These Essential Health Care Services are administratively and institutionally organized at district level offers 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 ministry of health and population and its constituent organization. Under federal government, now the pattern is shifted and its function are implementing through province government of lumbini province under Ministry of Health and pheriperal level health facilities are run through local level government with proper coordination of provinve and central government.

This chapter presents the findings related to the HO structure and systems, which covers following areas: service delivery points, management system, health service workforce, monitoring and evaluation system, IT and health information management and disaster management system.

1.4.1. Service Delivery Points

As a whole, there are altogether 126 peripheral health facilities (private and government) representing all ward of district. One 50 beded provincial hospital having CEONC services, 1 basic hospital, 2 PHCCs having BEONC services, 48 HPs, 22 Basic Health Service Center (BHSC), 11 Urban Health Clinic (UHC), 38 Community Health Unit (CHU) governed by local level and, 58 birthing centers, 178 PHC/ORCs, 222 Immunization Clinics and 227 were Immunization Session. With in the district, there are previous ward based FCHVs, so the total number of Female Community Health Volunteers (FCHVs) is 459. There are 38 IUCD and 59 Implant service sites and have planned to be listed and declared as availability of at least six FP methods in all health facilities including sayana press. Alltogether 47 Medical Abortion (MA) sites are listed in district. In total 84 SBA nurses in distict, having 12 RUSG sites. In addition,

Service Delivery Points

Type of service delivery points	Number
Provincial Government Hospital	1
Local Level Basic Hospital	1
PHCC	2
Private HF (Hospital and NGO)	3
Health Posts	48
Basic Health Service Center	22
Community Health Unit	38
Urban Health Center	11
CEONC Site	1
BEONC Sites	2
Birthing Centers	58
PHC Out-Reach Clinic	178
Immunization Clinic	222
Immunization Session	227
DOTS Center	74
ART Service Site	1
PMTCT Site	1
CB-PMTCT Sites	74
HTC Site	1
FCHVs	459
IUCD Service Sites	38
Implant Service Sites	59
Six FP methods Sites with Sayana press	36
Medical Abortion Site	47
RUSG Service site	12

with this other, few registered health clinics, pharmacies and national and international non-governmental organizations are working in health sector in the district with the close coordination of Health Office, Rolpa.

1.4.2. Management Systems

Meetings:

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

The monthly review meeting of the HF incharges at each municipal is organized on 8th day of every month. Monthly review meeting is regularly organizing at district level on the 15th day of every month, which is the major innovation of the HO, Rolpa.

All HFs have their own Health Facility Operational and Management Committee (HFOMC) lead by ward chairperson and their meeting used to be conduct routinely and as per need for the community levels quality health services. Femal Community Health Volunteers (FCHV) and Health Mother Group (HMG) Meeting has been organized each month in respective wards.

Current Staff's Sanctioned Post of Health Office, Rolpa

Current Staffs Sanctioned Post of Health Office (FY 2080/81)		
HO Staffs	**Numbers**	**Status**
a. Sr/Public Health Officer	1	Filled
b. HA/Public Health Supervisors	2	Filled
c. Public Health Nurse	1	Filled
d. Statistics Assistant/Officer	1	Filled
e. Cold Chain Assistant	1	Vacant*
f. Laboratory Technician	1	Filled
g. Administration Assistant/Officer	1	Filled
h. Accountant/Officer	1	Filled
i. Office Assistants	2	Filled
j. Driver	1	Filled
Total	**12**	

*Currently working as contract

Terms of Refrence (TOR): Health Office, Rolpa

1. Coordination, facilitation, liason to province and local level government under the health directorate and implementation of program as per guidance and direction of province.

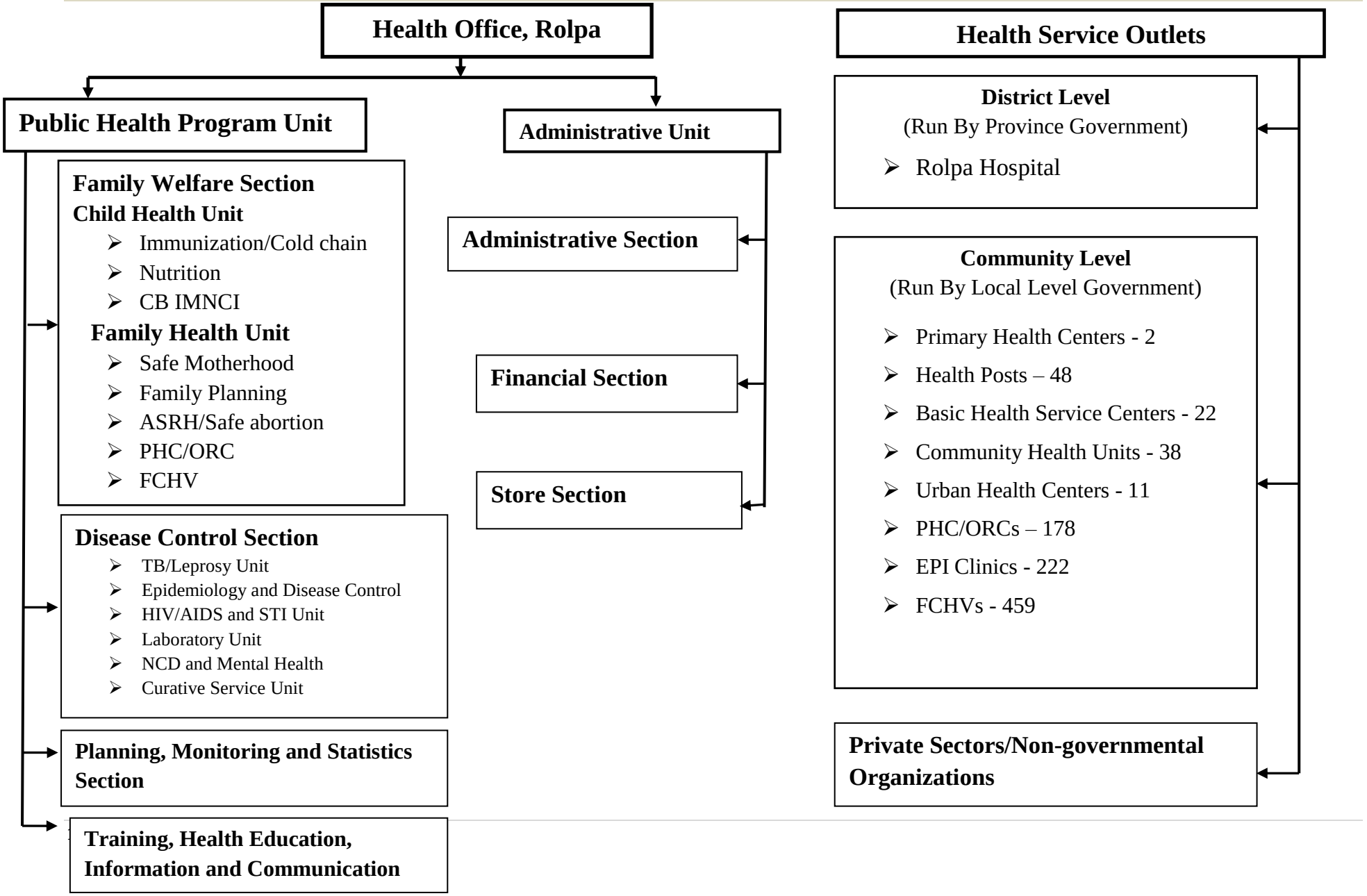
2. Prepare the storage and distribution plan of vaccine, essential and urgent medicine and equipments at quality control and monitoring under district through eLMIS system.
3. Facilitate and coordinate with the concern district stakeholders for the management of the public health disaster/epidemic and vector surveillance.
4. Facilitate and coordinate with the concern district stakeholders to conduct different public health campaigns.
5. Coordinate with local government and service outlets and concern stakeholders.
6. Study and analysis of integrated health information system, prepare plan and facilitate and share the feedback to 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 of the program activities and cooperatives health institutions.
9. Technical capacity building of the human resourses and organization
10. Coordinate, facilitate and implement of the province special health program and other regular public health programs (like: - tuberculosis, leprosy, family planning, lymphyatic filariasis, nutrition, measeals/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 province government
14. Multisectoral coordination and facilitation
15. Internal administration (Financial, Administration, and Management) related works.

Disaster Response Mechanism

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

In addition, there is local level Rapid Response Committee and RRT at all local level which has member's 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 mobilized and if the condition is out of their control RRT at the district level add the support and mobilize as per need. Likewise, if the district level RRT is also unable to control the situation then province health emergency operation center, national health emergency operation center and EDCD is 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 clinincs	Immunization Sessions		
1	Rolpa Mun	10	24	63	63	30	35	23	1
2	Sunchhahari RM	7	14	26	53	22	22	19	1
3	Thawang RM	5	9	17	27	14	14	11	1
4	Paribartan RM	6	10	37	45	22	22	20	1
5	Gangadev RM	7	9	40	33	15	15	14	1
6	Madi RM	6	10	35	36	14	14	14	1
7	Tribeni RM	7	7	45	45	22	22	18	1
8	Runtigadhi RM	9	12	47	57	32	32	26	1
9	Sunilsmriti RM	8	11	50	55	27	27	23	1
10	Lungri RM	7	20	50	45	24	24	10	1
Total		**72**	**126**	**410**	**459**	**222**	**227**	**175**	**10**

CHAPTER 2

FAMILY WELFARE PROGRAM

2.1. NATIONAL IMMUNIZATION PROGRAM

National Immunization Program (NIP) was formerly started from Expanded Program on Immunization (EPI) which was started in 2034 and is a P_1 program. It is one of the successful public health intervention program that has achieved several milestones and contributed in reduction of morbidity, mortality and disability associated with Vaccine Preventable Diseases (VPD).

NIP works closely with all three tiers of governments. At the federal level, it works with other divisions of DoHS, national centers of MoHP, and supporting partners. At the Provincial level, Health Directorate (HD) and its line agencies plans, executes and monitors the various immunization programs, Provincial Health Logistic Management Centre (PHLMC) executes the logistic plan including storage and distribution of vaccine and vaccine related commodities including coldchain management. At the local level, rural/municipal offices and its agencies are responsible for planning and implementation of immunization services through the fixed, outreach session and mobile clinic.

NIP, started as Expanded Program on Immunization (EPI) in 2034 BS, is a top priority and a successful initiative of MoHP, contributing in reduction ofmorbidity, mortality, and disability associated with vaccine-preventable diseases. 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 Mangsir 2080, 72 out of 77 districts and 724 out of 753 local levels have achieved 'full immunization' status. NIP significantly contributes to the decline in infant and child mortality, aiding in achieving MDG Goal 4.

Nepal, the first country in the South-East Asia Region with Immunization Act, 2072 and Immunization Regulation 2074, and provinces adopting their own acts, demonstrates the government's commitment to recognizing immunization as a fundamental right for all children. Alongside global, regional, and national guiding documents, the National Immunization Program has a Comprehensive Multi-Year Plan (cMYP) 2017–2021/22. National Immunization Strategy (2023-2030), aligned with the Nepal Health Sector Strategic Plan (2023-2030), will be the primary guiding document for national immunization program for next seven years.

Since FY 2069/70, Nepal has initiated and implemented a unique initiative program known as ''Full Immunization Program''. The program addresses the issues of social inequity in immunization as every child regardless of social or geographical aspects within an administrative boundary are meant to be fully immunized under this program. Over the years,

Nepal has participated as a witness of all stakeholders at all levels to achieve full immunization.
Since 2075/3/25(BS), Rolpa district has been declared the full immunization among the 0-15 month child and decalaring its sustainability each year with the full particiapation of local stakeholders.
Total 222 Immunization clinics are providing vaccination services throughout district, through trained vaccinators at fixed locations on 15th to 20th day of every month. Besides this, Rolpa Hospital, Reugha providing immunization services to the 0-15 month child in weekly basis on each Thursday, through the MCH clinic.

Guiding Documents of National Immunization Program
There are several Global, Regional and National guiding documents for NIP. The main documents, which have been taken in account and are, incorporated in cMYP 2017-21(AD) are Global Vaccine Action Plan, SEARO Vaccine Action Plan, National Immunization Act 2072 (BS) and Nepal Health Sector Strategy.

Vision
Nepal: a country free of vaccine-preventable diseases

Mission
To provide every child and mother high 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 immunization supply chain and vaccine management system for quality immunization services;
Objective 4: Ensure financial sustainability for immunization program;
Objective 5: Promote innovation, research and social mobilization activities to enhance best practices

Target Population (Rolpa District FY 2080/81)

Particulars	Target Population	Vaccines
Under one year Children	4712	BCG, DPT-HepB-Hib, OPV, Rota, fIPV, PCV and MR1 vaccine
12-23 month children	4672	JE, MR2, TCV
Total expected live birth	4802	Tetanus Diptheria (TD) vaccine

National Immunization Schedule (0-15month)/ Pregnant mother

Type of Vaccine	Number of Doses	Schedule
Tetanus Diphtheria (Td)	2	Pregnant women: 2 doses of Td one-month apart in first pregnancy, and 1 dose in each subsequent pregnancy
BCG	1	At birth or on first contact with health institution
DPT HepB-Hib	3	6, 10, and 14 weeks of age
Rota Vaccine	2	6 and 10 weeks of age
OPV	3	6, 10, and 14 weeks of age
PCV	3	6,10 weeks and 9 months of age
FIPV	2	14 weeks and 9 month of age
Measles-Rubella	2	First dose 9 months and 15 months of age
JE	1	12 months of age
TCV	1	15 months of age

Vaccine Distribution Center in the District

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

The Structure, Types and Uses Process of Vaccines

S.N.	Name of Vaccine	Dose	Type	Form	VVM	Use up to	MDVP	Sensitive
1	BCG	20	Live	Powder	Top	6 hr	No	Heat
2	Rota	1	live	Liquid	TOP	-	no	Heat /Cold
3	OPV	10	Live	Liquid	Side	3 days	Yes	Heat
4	FIPV	5	Killed	Liquid	Top	6 hrs	No	Cold
5	PVV	4	Killed	Liquid	Side	3 days	Yes	Cold
6	DPT, HepB Hib	10	Killed	Liquid	Side	3 days	Yes	Cold
7	MR	10	Live	Powder	Top	6 hr	No	Heat
8	TD	10	Killed	Liquid	Side	3 days	Yes	Cold
9	JE	5	Live	Powder	Top	1 hr	No	Heat
10	Tyophoid	5	Killed	Liquid	Top	3 days	Yes	Cold

Indicators of three years' trends (district)

Vaccination coverage of all antigens within Rolpa district is in fluctuation trends during last three year of duration. The vaccination coverage of BCG, DPT-HepB-Hib3, Rota and TD is in increasing trends where the MR1 and MR2 coverage has decreased as compared to previous year.

Immunization Coverage 3 Years Trends (Percentage)

All vaccine coverage is gradually increased in fiscal year 2080/81 than past two years in which JE vaccine coverage is high (97%) in last fiscal year among the all vaccine coverage. DPT 1 vs DPT 3, Rota 1 vs Rota 2, PCV 1 vs PCV 3 and MR 1 vs MR 3 vaccine coverage was high in fiscal year 2080/81

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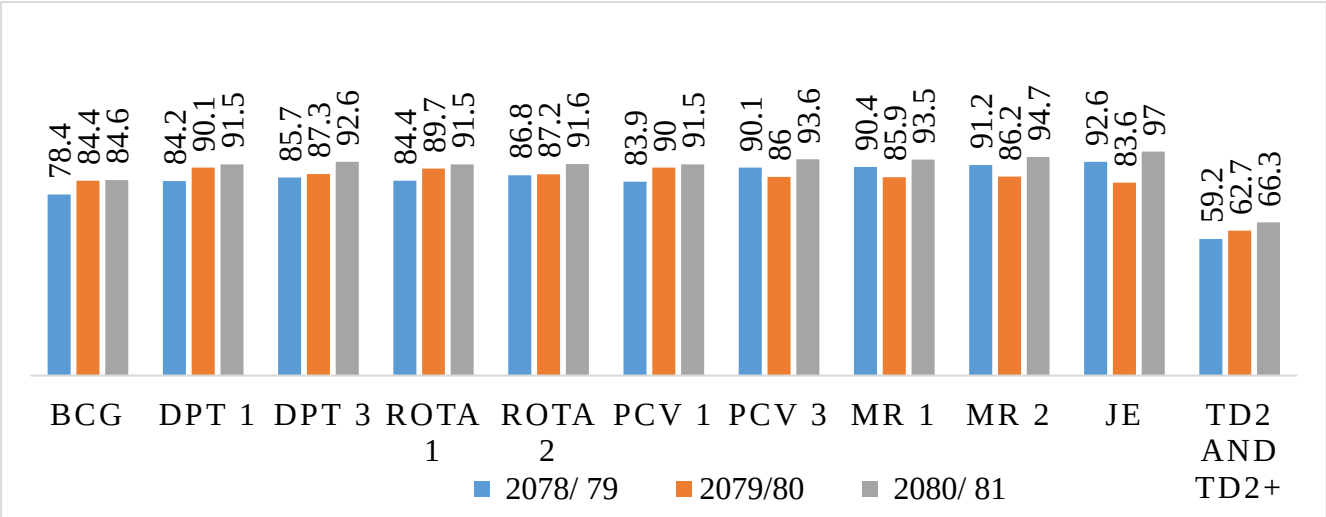
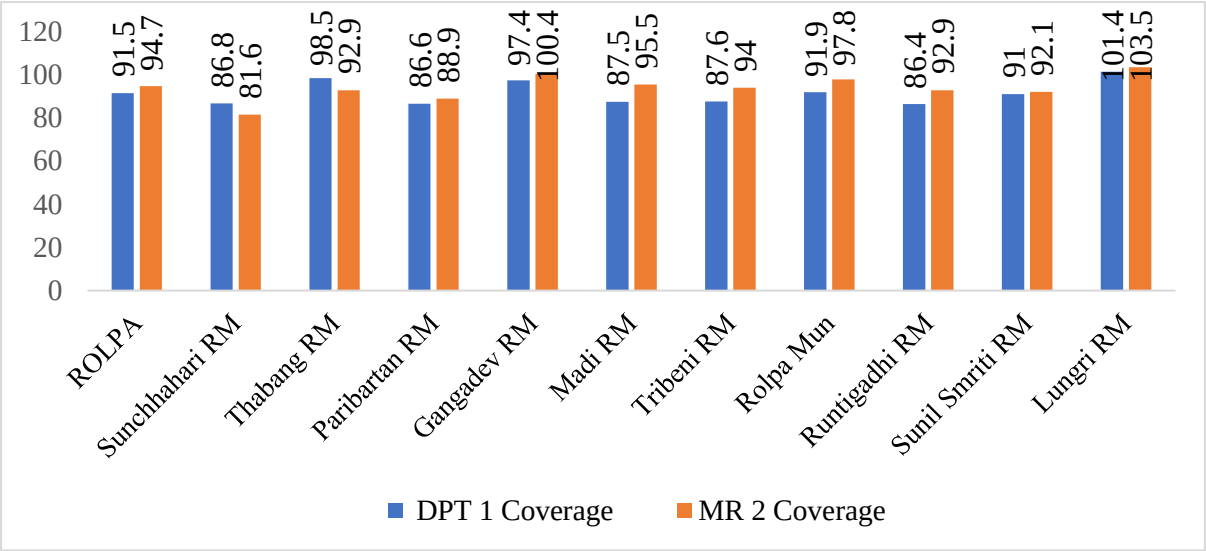


DPT-HepB-Hib1 and MR2 Coverage 2080/81 (Percentage)

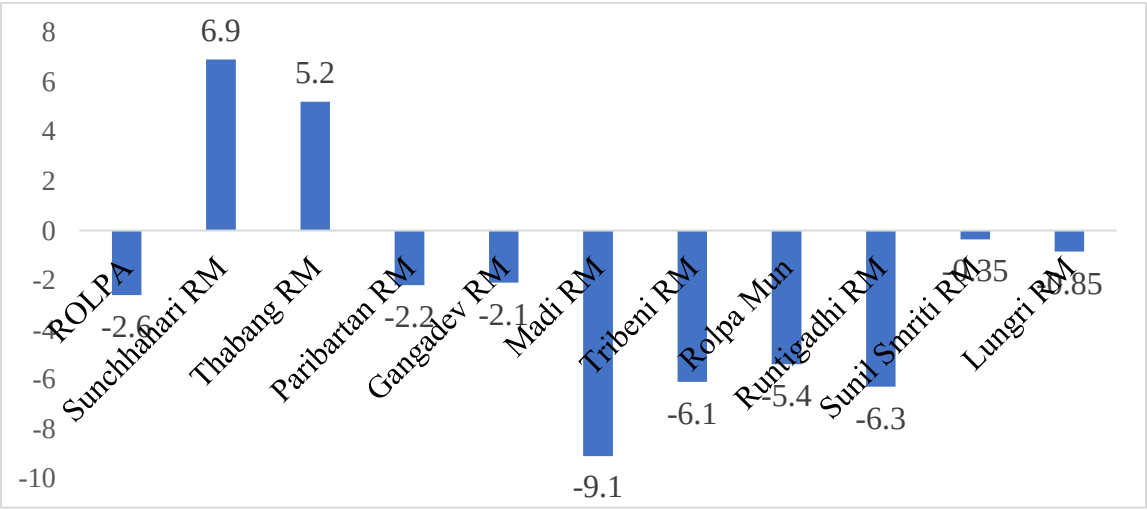
The coverage of DPT-HepB-Hib1 and MR2 in last fiscal year of Rolpa district (DPT-HepB-Hib1-91.5% and MR 2 94.7%) is satisfactory level where as DPT-HepB-Hib1 vaccine coverage in Lngri RM, Thabang RM, Rolpa Municipality, Sunilsmriti RM and Gangadev RM are more than 90% and other palikas coverage are less than 90%. Highly low coverage in Sunchhahari RM among the all palikas.



Drop Out:

Dropout in immunization program indicates the ultilization and the rate within acceptable limit (-10 to 10) is expected to ensure good utilization of services while, more dropout rates signify that there could be problems with recording and reporting or because of the miscalculated denominators. Except DPT+HepB+Hib-1 vs. DPT+HepB+Hib-3, dropout of other vaccine has decreased as compared to previous year. The dropout rate of the last three years exists within acceptable limit. (Except BCG vs MR during previous year may be due low institutional delivery that indicates referral).

DPT-HepB-Hib1 vs MR 2 Dropout 2080/81 (Percentage)



Categorization of Palika Based on Access and Utilization of Immunization (FY 2080/81)

National Imunization Program (NIP) also evaluates the status of the accessibility and utilization of immunization services. Local Level are categorized by CAT 1 to 4 on the basis of DPT-HepB-Hib1 coverage and dropout rate of DPT-HepB-Hib1 VS MR2 to know the accessibility and utilization of immunization services respectively.

Reviewing the overall local level (Thabang, Gangadev, Rolpa, Sunilsmriti and Lungri) of the district are in category I (having good accessibility and utilization of immunization services), no any palika are in category II and IV. Likewise, Paribartan, Sunchhahari, Runtigadhi Triveni and Madi belong to category III i.e (poor access and good utilization).

Category I (less Problem)	**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%)
Thabang RM Gangadev RM Rolpa MP Sunilsmriti RM Lungri RM **5 Local Level and District**	**No any LLG**	Paribartan RM Sunchhahari RM Runtigadhi RM Tribeni RM Madi RM **(5 Local Level)**	**No any LLG**
*All local levels as well as district have been declared and sustained as full immunization district			

Vaccine Wastage Rate (FY 2080/81):

Vaccine Wastage										
Organisation Unit	**BCG**	**DPT/HepB/Hib**	**Rota**	**OPV**	**JE**	**FIPV**	**TD**	**PCV**	**TCV**	**MR**
Rolpa Total	**87.7**	**25.1**	**0.75**	**26.5**	**48.3**	**33.7**	**40**	**11.3**	**31**	**55.9**
Sunchhahari	90.5	34	4.5	35.7	58.5	42.5	59	19.3	41	67
Thabang	89.4	31.1	0	33.1	54.9	46.6	46	12.3	34	68.4
Paribartan	85.2	19.6	0.41	19.6	46	31	38	8.6	25	51.3
Gangadev	84.6	23	1.1	21.1	38.6	24.3	42	9.6	26	44.3
Madi	87.1	26.7	0.32	26.8	41.7	29.5	39	9	33	51.9
Tribeni	88.7	25.7	-0.12	23.1	50.8	38	36	13.7	29	58
Rolpa Mun	87.9	28.2	0.92	33.6	52.1	36.9	42	13.7	33	58.4
Runtigadhi	89.6	27.3	-0.57	31	53.7	35.6	43	13.4	37	61.1
SunilSmriti	88.1	20.8	1.6	22.2	48.6	34.5	35	9.6	29	54.9
Lungri	85.5	19.9	0	20.2	37.6	24.1	28	6	21	44.9

All vaccine wastage rate is very high except Rota vaccine according to the bench mark of all palikas among with the district in fiscal year 2080/81 where as vaccine wastage bench mark is BCG-50%, JE-40%, DPT-HepB-Hib- 15%, PCV-5%, FIPV-10%, OPV-15%,Rota-5%,TCV-10% and TD-15%.

National Benchmark for Vaccine Wastage (Percentage)

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%

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 of higher vaccine wastage.

Major Activities Carried Out in FY 2080/81

1. Round yearly management and supply of the vaccines and related commodities to uninterrupted conduction of NIP sessions, clinics and hygiene promotion sessions
2. Basic Immunization Training to health workers
3. Declaration of Full Immunization Sustainability of district, local level and ward followed by linelisting and household survey
4. Supply for cold chain equipments and related logistics commodities to all distribution center
5. Repair and maintenance of cold chain equipments
6. Conducted vaccination campaign against covid-19 regularly in ward level in the different phase
7. Prepare, published and distribution of Immunization microplanning booklets, Immunization dairy, vaccine monitoring sheets, Immunization card and necessary form and format related to national immunization program.
8. Orientation of introduction of Covid-19 vaccine, AEFI and it's management to all Health Workers, vaccinators including FCHV.
9. Conducted the district level immunization coordination committee meeting semi-annually
10. Conducted Measales Rubella and IPV campaign throughout the district
11. Orientation regarding to the Immunization Act and regulation towards health workers and stakeholders
12. Conduction of District, Municipal and HF level immunization review meetings and micro planning preparation workshop
13. Data verification and quality monitoring to low/poor immunization covarage sites
14. Celebration of Baisakh month as the Immunization month to decrease drop-out rates and sensitization to the public.
15. Expansion of zero reporting sites of VPD Surveillance in all palikas
16. Supportive monitoring and supervision visit to health facilities and at community level

Covid-19 Vaccination Campaign

Organization	Total population	Target population (5-11 years)	Target population ≥12 years	Cumulative total (22 Aug 2023)					Cumulative 5-11 Years (22 Aug 2023)			
				1st dose	Full dose	Total	1st Additional dose	2nd Additional dose	1st dose	Full dose	Total	Additional dose
ROLPA	**236,755**	**30,778**	**182,301**	**172,380**	**182,908**	**355,288**	**99,283**	**3,163**	**33,663**	**31,363**	**65,026**	**-**
Sunchhahari RM	17,317	2,251	13,334	11,284	11,419	22,703	5,933	469	2,416	2,090	4,506	-
Thabang RM	11,031	1,434	8,494	7,651	8,563	16,214	4,476	292	1,375	1,284	2,659	-
Paribartaan RM	22,044	2,866	16,974	15,973	17,097	33,070	11,448	149	3,072	2,954	6,026	-
Gangadev RM	21,795	2,833	16,782	15,267	15,816	31,083	8,599	-	3,550	3,276	6,826	-
Madi RM	18,051	2,347	13,899	12,512	14,415	26,927	9,016	690	2,483	2,336	4,819	-
Tribeni RM	23,243	3,022	17,897	16,958	18,258	35,216	11,006	46	3,082	2,916	5,998	-
Rolpa Mun	36,913	4,799	28,423	26,357	31,331	57,688	17,605	1,342	4,889	4,649	9,538	-
Runtigadi RM	29,168	3,792	22,459	20,118	21,701	41,819	8,973	-	3,846	3,716	7,562	-
Sunil Smrity RM	30,588	3,976	23,553	22,899	23,127	46,026	11,676	175	4,424	4,117	8,541	-
Lungri RM	26,605	3,459	20,486	23,361	21,181	44,542	10,551	-	4,526	4,025	8,551	-

Organisation	Achievement against total population				Achievement against target (5-11 yrs) population			Achievement against target ≥12 yrs population			
	1st dose (%)	Full dose (%)	1st Additional dose (%)	2nd Additional dose (%)	1st dose (%)	Full dose (%)	Additional dose (%)	1st dose (%)	Full dose (%)	1st Additional dose (%)	2nd Additional dose (%)
ROLPA	**72.8**	**77.3**	41.9	1.3	**109.4**	**101.9**	0.0	**76.1**	**83.1**	54.5	1.7
Sunchhahari RM	65.2	65.9	34.3	2.7	107.3	92.8	0.0	66.5	70.0	44.5	3.5
Thabang RM	69.4	77.6	40.6	2.6	95.9	89.5	0.0	73.9	85.7	52.7	3.4
Paribartaan RM	72.5	77.6	51.9	0.7	107.2	103.1	0.0	76.0	83.3	67.4	0.9
Gangadev RM	70.0	72.6	39.5	0.0	125.3	115.6	0.0	69.8	74.7	51.2	0.0
Madi RM	69.3	79.9	49.9	3.8	105.8	99.5	0.0	72.2	86.9	64.9	5.0
Tribeni RM	73.0	78.6	47.4	0.2	102.0	96.5	0.0	77.5	85.7	61.5	0.3
Rolpa M	71.4	84.9	47.7	3.6	101.9	96.9	0.0	75.5	93.9	61.9	4.7
Runtigadi RM	69.0	74.4	30.8	0.0	101.4	98.0	0.0	72.5	80.1	40.0	0.0
Sunil Smrity RM	74.9	75.6	38.2	0.6	111.3	103.5	0.0	78.4	80.7	49.6	0.7
Lungri RM	87.8	79.6	39.7	0.0	130.9	116.4	0.0	91.9	83.7	51.5	0.0

Issues/ Challenges, Recommendations and Responisibilities

Issues/Challenges	Recommendations	Responsibilities
Program Duplication in district and at Municipal level	Avoid the duplication of program Coordination with the Palikas for overview of the program activities and sharing	MoHP/DOHS/MOH HO and LLG
Provision of compensation for field activities is not uniform for all staffs	Provision of compensation for field activities should be provided equally for all staffs.	MoHP/DOHS/ MoF/MOH
Inadequate budget for vaccine transportation for local level	Proper allocate the budget for vaccine transportation as per need	MoH, FWD, DoHS
Electicity backup system round the year	Provision of electicity backup in district coldchain 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 DQSA program	HF, HO, HD, FWD

2.2. INTEGRATED MANAGEMENT OF NEONATAL AND CHILDHOOD ILLNESSES

The CB-IMNCI program has a vision to provide targeted services to 90% of the estimated population by 2030 as shown in the diagram guided by Vision 90 by 30. Nepal has implemented both the community based and facility based IMNCI approaches. CB-IMNCI is an integration of CB-IMNCI and CB-NCP Program as per the decision of MoHP on Ashoj 2071 BS (October 14, 2015). This was scaled up to all 75 districts in FY 2071/72 (2016); to all current 77 districts. The program aims to address major childhood illnesses like Pneumonia, Diarrhoea, Malaria, Measles and Malnutrition among under 5 year children in a holistic way. 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 CB-IMNCI program is reported to contribute in reducing the prevalence of pneumonia and diarrhea significantly. 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.

In 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 appear among sick newborn and child. Health workers will counsel, and provided the health service like management of non-breathing cases, skin-to-skin contact and management of neonatal sepsis and common childhood illness. In addition, program has provisioned the post-natal visits by trained health workers through primary health care outreach clinic.

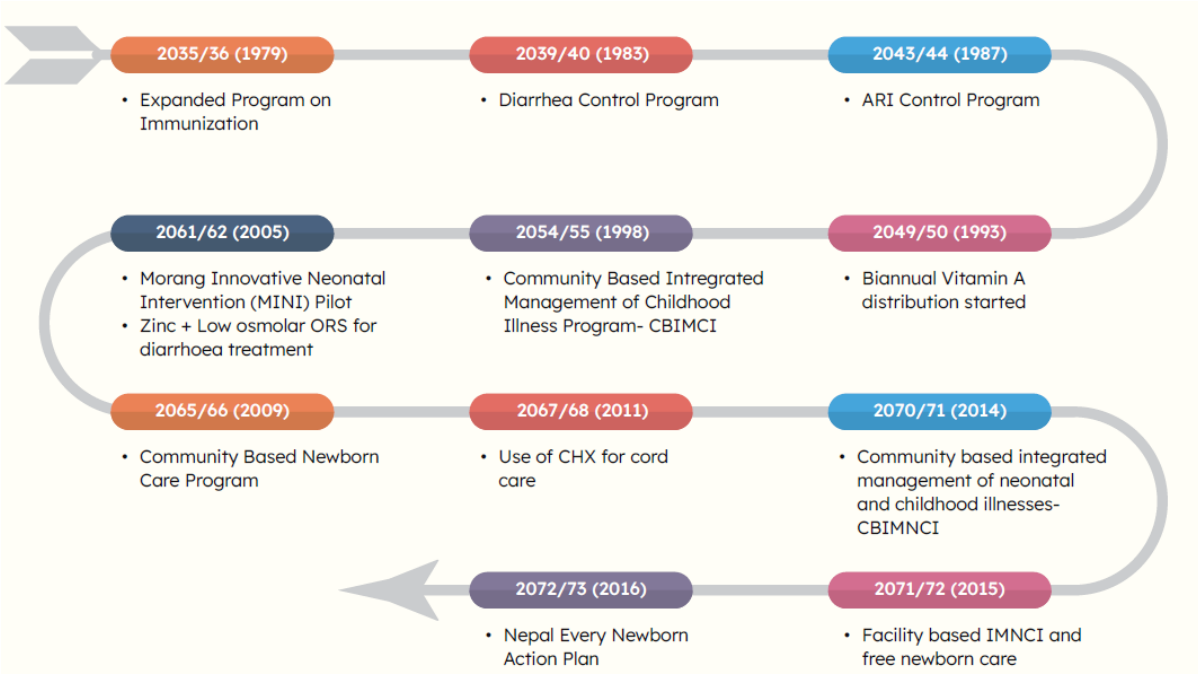


Fig: Development of CB-IMNCI Program in Nepal (year parenthesis is in AD)

Goal:

Improve newborn and child survival and ensure healthy growth and development.

Indicators per 1000 live birth	NHSS (2015-2020)	NENAP (2035)	SDG
Neonatal mortality Rate	17.5	11	At least as low as 12
Still birth		13	
U_5 Mortality Rate	28	21	At least as low as 20*

*Target revised by National Planning Commission, Nepal, and global target is 25 per 1000 live birth

Objectives:

- To reduce neonatal morbidity and mortality by promoting essential newborn care services and managing major causes of illness.
- To reduce morbidity and mortality by managing major causes of illness among under 5 years' children

Strategies:

- Quality of care through system strengthening and referral services for specialized care
- Ensure universal access to health care services for new born and young infant
- Capacity building of frontline health workers and volunteers
- Increase service utilization through demand generation activities
- Promote decentralized and evidence-based planning and programming

Major Interventions

Newborn Specific Interventions

- Promotion of birth preparedness plan
- Promotion of essential newborn care practices and postnatal care to mothers and newborns
- Identification and management of shortness of breath of babies at birth
- Identification and management of preterm and low birth weight babies
- Management of sepsis among young infants (0-59 days) including diarrhoea

Child Specific Interventions

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

Capacity building/enhancement & quality assurance

- Onsite Coaching (guidelines development /revision, coach development, and coaching & mentoring o Routine Data Quality Assessmen

Cross Cutting Interventions

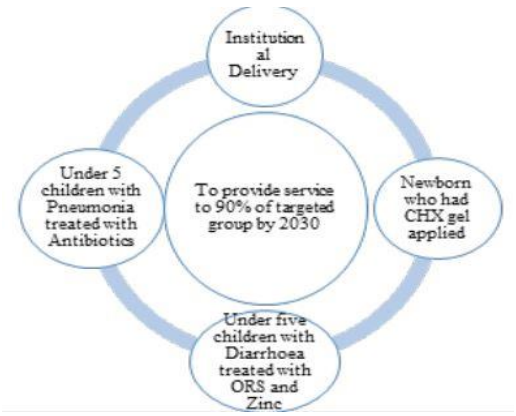
- Promote the behavior change communications for healthy pregnancy, safe delivery and promote personal hygiene and sanitation,
- Improved the knowledge regarding the Immunization and Nutrition and care of sick children,
- Improved the interpersonal communication skills of HWs and FCHVs,
- Increased community participation through equity and access program (EAP)

Vision 90 by 30: -

CB-IMNCI program has a vision to provide targeted services to 90 percent of the estimated population by 2030 (targated also for 2020) as below:

To provide service to 90% of target group by 2030:

- Institutional delivery
- New born who had CHX gel applied
- Under 5 children with diarrhoea treated with ORS and Zinc
- Under 5 children with Pneumonia treated with Antibiotics



Major Indicators:

Indicators	**2078/79**	**2079/80**	**2080/81**
ARI Incidence Rate among children of <5 Years Children	427.9	360.5	397.1
% of Pneumonia among <5 children treated with antibiotics	86.3	100.1	100
Incidence of Diarrhoea /1000 <5 Year Children	182	208.4	250.9
% of Diarrhea Cases Treated by Zinc and ORS	100	100.1	100.4
% of children under five years with diarrhea suffering from Severe dehydration	0	0.02	0.24
Neonatal Indicators			
% of infants aged 0-2 months with Local Bacterial Infection	45.5	32.5	29.2
% of PSBI cases among expected live births	1.2	1.1	1.2
% of infants aged 0-2 months with PSBI	14.9	9.4	7.7
% of infants aged 0-2 months with PSBI receiving a first dose of Gentamycin	100	96.5	98.2
% of infants aged 0-2 months with PSBI receiving a complete dose of Gentamycin	64.6	57.9	57.9
Percentage of newborns applied chlorhexidine (CHX) gel immediately among reported live birth	97.4	99	100

Incidence of ARI/1000 Under 5 years' children has been increased in FY 2080/81 as compared to previous years ie. Incidence of pneumonia among ARI per 1000 has also decreased from 100.1 to 100 as compared to 2079/80. Cent percent of Pneumonia among <5 children treated with antibiotics in all health facilities.

Likewise, Incidence of diarrhoea has been slightly increased in trend than last year i.e. 100.1 to 100.4. The proportion of severe dehydration has been increased. All cases of diarrhoea were treated by Zinc and ORS.

Allmost all i.e. 98.2% of young infants aged 0-2 months with PSBI receiving a first dose of Gentamycin. Likewise; more than half i.e. 57.9% of the PSBI cases among under two months old children received a complete dose of Inj. Gentamycin at the district level in FY 2080/81.

Major Activities carried out in FY 2080/81

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

Issues/Challenges, 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 Regular supply	FWD, PHLMC
Poor recording and reporting as per guidelines	Maintain CB-IMCI register properly at HF, discuss with FCHV about recording and reporting as per guideline	HO, LLG , HF
Poor referral mechanism	Strengthen the referral mechanism	HO/HF/LLG
CBIMNCI un-train health workers in health facilities	Provision of training regularly	MoH/HTC
Low coverage & quality of health care	Strengthen quality improvement system -Enhance the use of health facility quality improvement tools -Onsite coaching -Supportive supervision & mentoring	HD/HO/LLG/HF

2.3 NUTRITION PROGRAM

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 15% to 8%, respectively. However, challenges persist, with a 19% prevalence of underweight among children less than five years. Anemia still 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 program is guided by the Nutrition Strategy, 2077. Different nutrition programs are in different phases of piloting, scale up and nationwide coverage.

So GoN, in alignment with international and national declarations and national health policies, committed to ensuring that its citizens have adequate food, health and nutrition. The Constitution (2015) ensures the right to food, health and nutrition to all citizens. Along with the federal Government, the province 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) is responsible for providing nutrition services throughout the province in cooperation and collaboration with federal government and local levels, as well as development partners.

Vision: To prepare well-nourished, healthy, happy and capable citizens

Mission: To build a nutrition friendly society

Goal: To reduce the current problem of malnutrition in line with the Sustainable Development Goals by 2030.

Strategies:

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

Focus on Nutrition

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 third phase during 2023-30). The UN General Assembly declared the 2016-2025 periods as the Decade of Action on Nutrition.

Policy Initiatives

The National Nutrition Policy and Strategy 2004 address all forms of malnutrition including under-nutrition and over-nutrition, which provides the strategic and programmatic directions in the health sector. Whereas the MSNP 2012 provides a broader policy framework within and beyond the health sector under a Food and Nutrition Security Secretariat of the National Planning Commission that coordinates its implementation. The National Health Policy 2076, **Policy no. 6.13** highlights improved nutrition via the use and promotion of quality and nutritious foods produced locally to fight malnutrition.

Current Global Nutrition Targets

a. Sustainable Development Goal (SDG)

Goal 2-End hunger, achieve food security and improved nutrition and promote sustainable agriculture

- By 2030, end hunger and ensure access by all people, in particular the poor and people in vulnerable situations, including infants, to safe, nutritious and sufficient food all year round;
- By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons;
- By 2030, double the agricultural productivity and incomes of small-scale food producers, in particular women, indigenous peoples, family farmers, pastoralists and fishers, including through secure and equal access to land, other productive resources and inputs, knowledge, financial services, markets and opportunities for value addition and non-farm employment;

b. Global Nutrition Target by 2025 (World Health Assembly) [WHA]

- Reduce the global number of children under five who are stunted by 40 percent
- Reduce anaemia in women of reproductive age by 50 percent
- Reduce low birth weight by 30 percent
- No increase in childhood over weight
- Increase the rate of exclusive breastfeeding in the first six months up to at least 50 percent
- Reduce and maintain childhood wasting to less than 5 percent.

Progress status and targets of nutrition indicators

Indicators	Status (%) NDHS		Targets (%)		
	2016	2022	MSNP 2022	WHA 2025	SDG 2030
Stunting among U5 children	36	25	28	24	15
Wasting among children (U5)	10	8	7	<5	4
Underweight among children (U5)	27	19	20	15	10
Anaemia among children under 5 years	53	43	28	20	<15

Anaemia among children under 2	68		-	60	<50
Anaemia in adolescent women (15-49)	43.6	34	25 (for 10-19)	35	<25
BMI (<18.5kg/m2) among women aged 15-49	17		12	8	<5
Anemia among pregnant women	46		-	35	<25

National Nutrition Strategy 2077

This strategy was prepared to determine the strategic method and implementation framework suitable for the transformed federal structure and based on NHP 2076. This strategy has been prepared to incorporate the nutrition related strategies included in the fifteenth plan 2076/77-2080/81. The duration of this strategy will be from 2077 to 2087 (2020 to 2030). Thereafter (if necessary, even earlier) this strategy will be modified as required.

Basic principles and concepts

- Federally structured nutrition plan and activities;
- Gender equality and social inclusion;
- Program expansion to underserved groups and communities;
- Transparency, responsibility, and accountability;
- Good governance;
- Evidence-based nutrition service;
- Private sector engagement;
- Mobilization of local resources;
- Community participation

Objectives:

- Improve the nutritional status of infant, young children, adolescent girls and women by increasing access to nutrition specific and nutrition sensitive services.
- Improve the quality of nutrition specific and nutrition sensitive interventions and build capacity of the service providers.
- Increase the demand of nutrition specific and nutrition sensitive interventions through public awareness,
- Promote good nutrition behaviors and inhibit harmful behaviors.
- To increase the scope of nutrition services in accordance with time.

The key strategical areas of National Nutrition Strategy 2077 are:

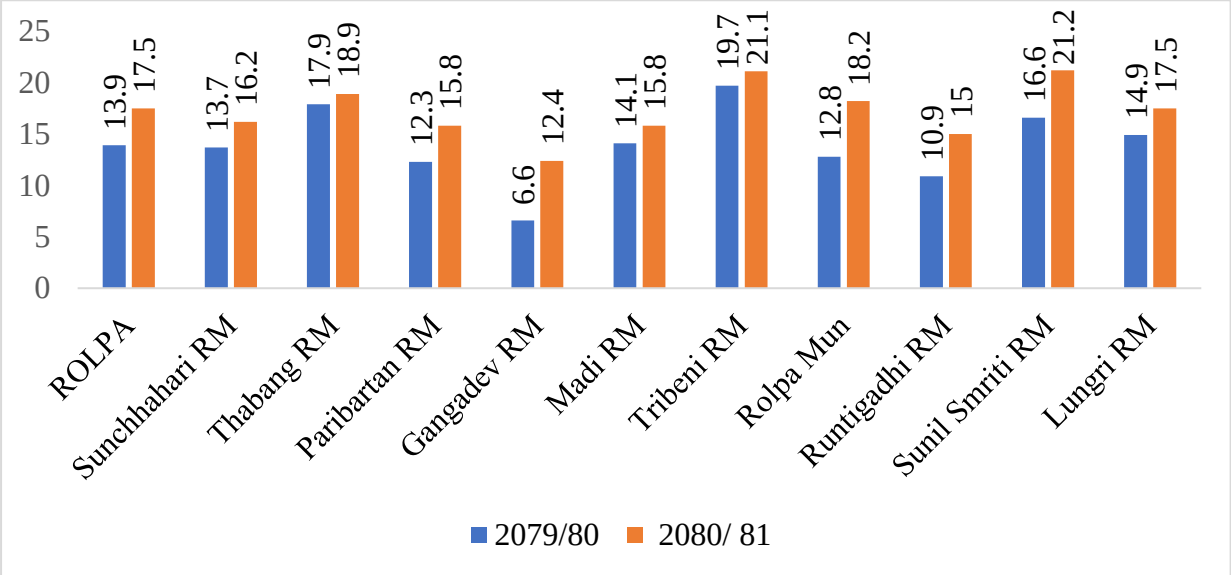
Key Strategy	Strategies
Multi-sectoral nutrition policy and programs including food security will be updated and implemented with high priority	▪ To continue, strengthen and expand the life cycle-based nutrition service ▪ To continue coordination and support to improve the quality of nutrition sensitive services ▪ To increase the capacity of nutrition service providers to provide nutrition services ▪ To make institutional arrangements and strengthen in accordance with the federal structure for the implementation of the programs and activities decided by the Multisector Nutrition Plan. ▪ To strengthen multi-sectoral coordination and cooperation ▪ To integrate nutrition services with other health sector programs ▪ To strengthen and promote nutrition related information and communication ▪ To conduct special nutrition programs for the inaccessible classes, communities and regions ▪ To promote nutrition research ▪ To make the monitoring and evaluation of nutrition services effective ▪ To take appropriate initiatives to address the nutritional needs of senior citizens
Short-term, medium-term and long-term measures will be adopted at all levels with emphasis on food diversification and balanced diet to improve the micro-nutrition status of different age groups including women and children.	▪ Supplementation to prevent, control and treat micronutrient deficiencies (Short term strategy) ▪ To fortify various micronutrients in food to prevent micronutrient deficiency in women, adolescents and children (Mid-term Strategy) ▪ To conduct programs for social behaviour change to prevent micronutrient deficiency in women, adolescents and children (Long term strategy)
Programs will be developed and operated by strengthening school health programs and nutrition education	▪ To strengthen and expand the school health and nutrition program
Domestic production will be promoted by encouraging the consumption of various nutritious and healthy foods.	▪ To promote domestic food production by encouraging consumption of various nutritious and healthy foods

Major Indicators of Nutrition Programm (3 years trend)

Indicators	Fiscal years		
	2078/79	2079/80	2080/81
Percentage of Children age 0-11 months newly registered for Growth Monitoring	96.3	90.7	94
Percentage of Children aged 12-23 months newly registered for Growth Monitoring	84.7	7.1	3.8
Average number of Visit among 0-23 months children for growth monitoring	5.9	13.9	17.5
Percentage of children aged 0-23 months register and visited for Growth Monitoring who were under weighted	1.5	1.6	1.3
Percentage of Children below 6 months exclusively breastfeed among registered for growth monitoring,	59.6	72.77	86.8
% of children aged 6-8 months registered for growth monitoring who received solid, semi- solid or soft foods	56.8	66.8	80.6

Above table shows, that the percentage of children age 0-11 months newly registered for Growth Monitoring is gradually increased in last fiscal from FY2079/80 (90.7 to 94%) in the Rolpa district. Percentage of Children aged 12-23 months newly registered for Growth Monitoring trend is drastically discreased from FY 2079/80 to 2080/81. Simlilarly percentage of children below 6 months exclusively breastfeed among registered for growth monitoring slightly increased trend which is good.

Growth Monitoring status in Rolpa (2 years' trend)



Average growth monitoring of 0-23 month children in FY 2080/81 was 17.5%, which was radically increased.

Coverage of Iron, Folic Acid and Vitamin-A Distribution

Since 1998, the MoHP has been providing iron foliate (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.

Indicators	Fiscal years		
	2078/79	2079/80	2080/81
% of women who received 180 Iron during pregnancy	58.8	64.9	69.4
% of postpartum mother who received 45 days supply of IFA supplement	182.6	98.8	98.7
Percentage of postpartum women who received Vitamin A supplementation	63.3	98.8	98.6

Above table shows that, percentage of women who received 180 tablet Iron during pregnancy has been discreased than the last FY year. As per the policy of MOHP, every mother is supplied with a 'Vitamin A' capsule in the postpartum period. HWs provide 'Vitamin A' capsule to mothers immediately after delivery and in case of home delivery FCHVs provide Vitamin A at their first visit. Percentage of postpartum women who received Vitamin A supplementation has been also decreasing trend in last fiscal year as compared FY 2079/80.

Bi-annual Vitamin 'A' and Albendazole tablet Distribution

Biannual Vitamin A and Albendazole distribution, a successful program of Nepal has notable contribution to reduce child morbidity and mortality (reducing childhood anemia with control or parasitic infestation through public health measures). FCHVs distribute the Vitamin A capsules to young children (6-59 months) and deworming tablets to 12-59 months, twice a year (Baisakh and Kartik) through national campaign. The achievement is over 100 percent during last three FYs but the MNP distribution is increasing trend i.e 20.4 to 47%.

Indicators	2078/79	2079/80	2080/81
% of children aged 6-59 months who received vitamin A supplementation in last six months (Baishak)	97.24	95.35	91.38
% of children aged 12-59 months who received anthelminthic in last six months (Baishakh)	85.59	83.58	90.80
% of children aged 6-23 months who received at least one cycle (60 Sachets) Baal Vita (MNP)	21.7	20.4	47
% of children aged 6-23 months who received at three cycle (180 Sachets) Baal Vita (MNP) in last 18 month	2.4	2	10.5

Outpatient Therapeutic Centers (OTC)

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

OTC center and total number of children aged 6-59 months admitted in OTC (FY 2080/81)

Local Level Name	Health facility Name (OTC Center)	No. of children aged 6-59 months admitted in OTC (New)
Sunchhahari RM	Powang HP	12
Thabang RM	Thabang Basic Hospital	1
Paribartan RM	Kewari HP	6
Gangadev RM	Jinabang HP	9
Madi RM	Ghartigaun HP	5
Tribeni RM	Nerpa HP	8
Rolpa Mun	Liwang HP	0
Runtigadhi RM	Holeri PHC	41
Sunil Smriti RM	Sulichour PHC	5
Lungri RM	Badachour HP	7
Total		**94**

The above table shows that, total number of children aged 6-59 months admitted in OTC in the fiscal year 2080. The cases are started to idetified after implementation of CNSI training to the health workers as well as to the FCHVs.

Major Activities Carried Out in FY 2080/81

- Biannual Distribution of Vitamin A and Albendazole tablet under 5 years children
- Screening of the malnourished children under 5 years of all palikas
- Celebration of breast-feeding promotion week, Nutrition Week and Iodine Month etc
- Regular growth monitoring of Under two years children
- 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 monitored the status accordingly
- Multi-Secteral Nutritional programme conducted by local level
- SHN week celebration throughout the district
- IEC/BCC intervention through local media and publications
- Treatment and management of malnourish children and support to improvements and Refer the severe malnourish cases to nutritional rehabititative home for further management
- Coordination with relevant stakeholders for cross cutting issues regarding health and nutrition

Result of screening of the malnourished children under 5 years of all palikas.

Name of LLG	Total no. of screened wards	No of screened children	Result			% of malnourished children
			Normal	Moderate	Severe	
Rolpa Mun	3	847	833	14	0	1.65
Sunchhahari RM	3	444	417	20	7	6.08
Thawang RM	3	456	394	57	5	13.59
Paribartan RM	3	659	630	28	1	4.40
Gangadev RM	3	723	704	18	1	2.62
Madi RM	3	942	921	21	0	2.22
Tribeni RM	3	836	805	31	0	3.70
Runtigadhi RM	3	661	642	18	1	2.87
Sunilsmriti RM	3	976	964	11	1	1.22
Lungri RM	3	1101	1081	20	0	1.81
Total	**30**	**7645**	**7391**	**238**	**16**	**3.32**

Above table shows that, HO Rolpa done the screening to the 7645 childern of 30 ward of all palikas where found the 238 child were moderate malnourished and 16 children were severe malnourished. In overall 3.32% child were malnourished which is not good conditioning in Rolpa district.

Issues/Challenges, Recommendations and Responsibilities:

Issues	Recommendation	Responsibilities
Poor recording and reporting of all nutritional indicators	-Provide onsite coaching to improve the recording and reporting -Provide HMIS training to newly recruited HWs.	MoH/HD/HO/LLG/HF
Less priorities on nutritional promotional activities by local level government	-Program and activities should be planned as stated in multisectrol nutritional plan and linkup with other governmental priorities	LLG
Unavailability of nutritional rehabilitation home in district	One nutritional rehabilitation home in each district need to be established	MoHP/DoHS/MoH
Poor linkages between the line agencies and stakeholders	Establish the linkages between concern stakeholder like agriculture, livestock and education sector etc. to quality improvement of nutritional status.	MoH/HD/HO

2.4. MATERNAL AND NEWBORN HEALTH

Government of Nepal, is committed and prioritizes the agenda of maternal and newborn health (MNH), and has included MNH services in the BHS package. The long journey of investment in MNH started with the milestone in 2054/55 (1998) when the government's Safe Motherhood Policy supplemented by National Policy on Skilled Birth Attendants (SBAs) 2062/63(2006) adopted two key strategies to improve maternal health: ensuring that a 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 to be barrier in accessing health care. There were huge differences in access to health facilities across Nepal's geographic terrain with only 41% of rural households living within 30 minutes' travel time from a health institution, compared to 89% of urban households and differences in wealth, with only 29% of the poorest quintile living within 30 minutes of a health institution compared to 57% of the rich. Given this situation, encouraging women to give birth at a health institution was considered by GoN an important part of the strategy to improve maternal health. Nepal has significantly reduced maternal mortality ratio (MMR) from 539 in 1996 to 151 in 2021.

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 of this progress, accelerated efforts are needed to meet the SDG targets by 2030-aiming for a MMR below 70 per 100,000 live births and Neonatal Mortality Rate (NMR) below 12 per 1,000 live births. Furthermore, FWD has given continuity to budget allocation for human resource support for MNH services. In FY 2079/80, a significant share of FWD's budget was invested for recruiting human resource staff nurses at hospital, Auxiliary Nurse Midwives (ANMs) for Basic Health Service Centers (BHSCs), Primary Health Care Centers (PHCCs) and Birthing Centers (BCs) and skill mixed human resource need for Comprehensive Emergency Obstetrics and Newborn Care (CEONC) sites, public hospitals with infrastructure but lacking human resources, to ensure 24x7 MNH services.

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 has adopted in Nepal:

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

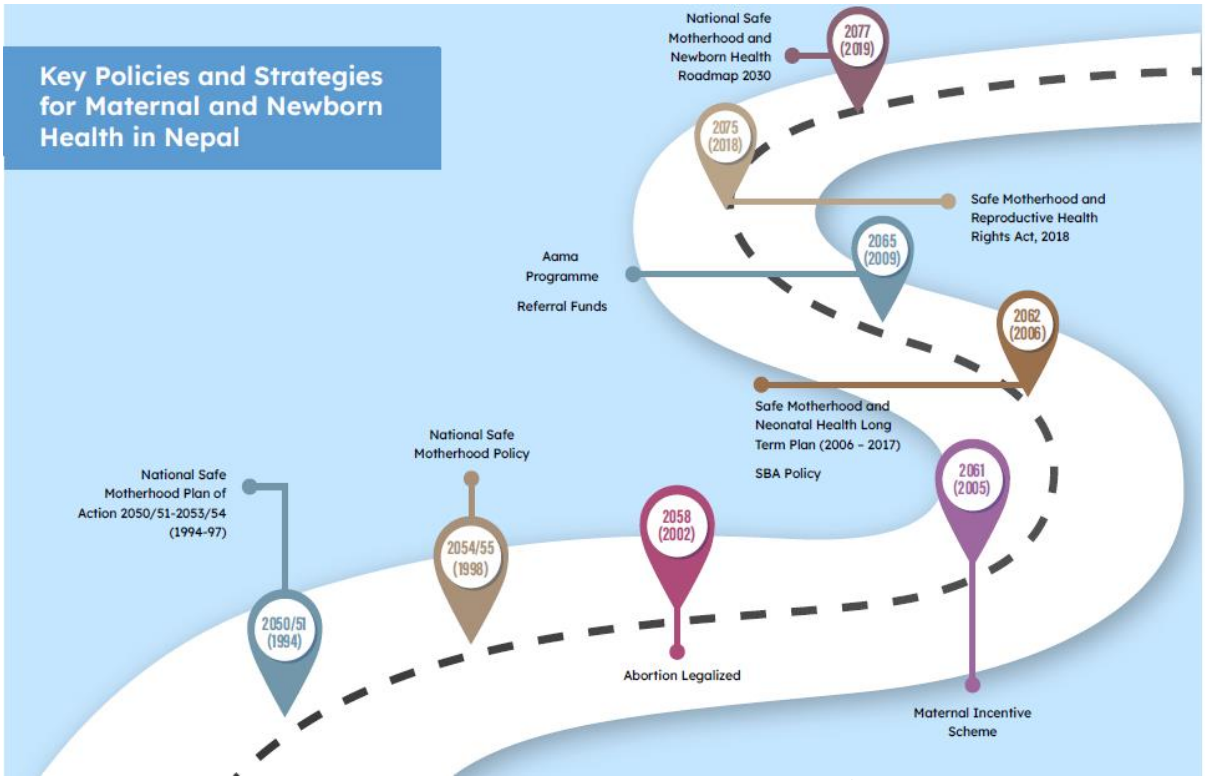


Figure: Key policies and strategies for maternal and newborn health in Nepal

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 PHCC (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 concern stakeholders throughout the district.

Main strategies of the Safe Motherhood Program

1. Promoting inter-sectoral coordination and collaboration at Federal, Provincial, districts and Local levels to ensure commitment and action for promoting safe motherhood with a focus on poor and excluded groups

2. Strengthening and expanding of delivery sites by SBAs and providing basic and comprehensive obstetric care services at all levels. Interventions include:

- developing the infrastructure for delivery and emergency obstetric care;
- standardizing basic maternity care and emergency obstetric care at appropriate levels of the health care system;
- strengthening human resource management training and deployment of advanced skilled birth attendant (ASBA), SBA, anesthesia assistant and contracting short-term human resources for expansion of services sites;
- establishing a functional referral system with air-lifting for emergency referrals from remote areas, the provision of stretchers in Palikas wards and emergency referral funds in all remote districts;

3. Strengthening community-based awareness on birth preparedness and complication readiness through FCHVs and increasing access to maternal health information and services.

4. Supporting activities that raise the status of women in society

5. Promote to research on safe motherhood to contribute to improved planning, higher quality services and more cost-effective interventions

Major Activities included in Safe Motherhood Program

1. Antenatal Care

- Continue at least four Focused Antenatal Check -up visits (FANC): first at 4th month (8-12 weeks), second at 6th month (24-26 weeks), third at 8th month (32 weeks) and fourth at 9th month (36-38 weeks) of pregnancy and promote 8 ANC contacts: 1st up to 12 weeks, 2nd at 20 weeks, 3rd at 26 weeks, 4th at 30 weeks, 5th at 34th weeks, 6th at 36 weeks, 7th at 38 weeks and 8th 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

Delivery Care

Delivery care services include:

- Skilled birth attendants at deliveries (facility-based)
- Early detection of complicated cases and management or referral after providing obstetric first aid by health worker to appropriate health facility where 24 hours emergency obstetric services are available
- Obstetric first aid at HFs if complications occur, using Emergency Obstetric Care Kit (EOC kit)
- Identification and management of complications during delivery and referral to appropriate health facility as and when needed
- Registration of births and maternal and neonatal deaths

2. Postnatal Care

Postnatal care services include:

- Four postnatal visits: First visit within 24 hours of delivery, second visit on the third day and third visit on seventh day and fourth visit is 42 days of after delivery.
- Identification and management of complications of mother's and newborn in postnatal period and referral to appropriate health facility as and when needed.
- Promotion of exclusive breast feeding
- 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

3. 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 attendant both at home and health facility, immediate newborn care (warmth, cleanliness, immediate breastfeeding, cord care, eye care and immunization) and newborn resuscitation.

4. Nyano Jhola Programme

The Nyano Jhola Programme was launched in 2070/71 to protect newborn 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 programme was interrupted due to financial constraints, however MOH allocated extra budget due to popular demand.

5. 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 (caesarean section), anesthesia and blood transfusion along with BEOC functions. Safe blood transfusion is an essential part of CEOC, and to support this, national blood transfusion policy was revised in 2006 and blood transfusion guideline developed.

6. Safe Abortion Services

Preventing unwanted pregnancies through a 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 globally need to make this service available in order 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 technique with effective pain management, post procedure family planning information and service to ensure women are able to plan when to have children and avoid further unwanted pregnancies.

Only trained and registered doctors as well as health workers specially nursing staffs can provide safe abortion services at the HFs approved by government, with the consent of women by following the protocol.

Aama surakshya program and free newborn programme

Initiated as Maternity Incentive Scheme in 2061 (2005) by providing transport incentives to women to deliver in health facilities, the program gradually covered user fees of all types of delivery care in 25 low human development index (HDI) districts in 2062 (2006) and was expanded nationwide as the Aama Programme in 2065 (2009). In 2068 (2012), separate 4 ANC incentives programme was merged into it and in 2074 (2017) free newborn programme was also merged with Aama Programme. The program incentivizes the women and the health facilities for health service utilization covered by the program. Health facilities get reimbursement by unit cost; NPR 2,500 for normal delivery, NPR 4,000 for complicated delivery, NPR 10,000 for caesarean 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 level of case.

Maternal and perinatal death surveillance and response (MPDSR)

As per the Maternal and Perinatal Death Surveillance and Response (MPDSR) guidelines, all of the local level and health facilities formed their committee including distrit level. The committee meeting has to commence within 72 hours of every maternal death.

Three year Status of MPDSR in Rolpa district

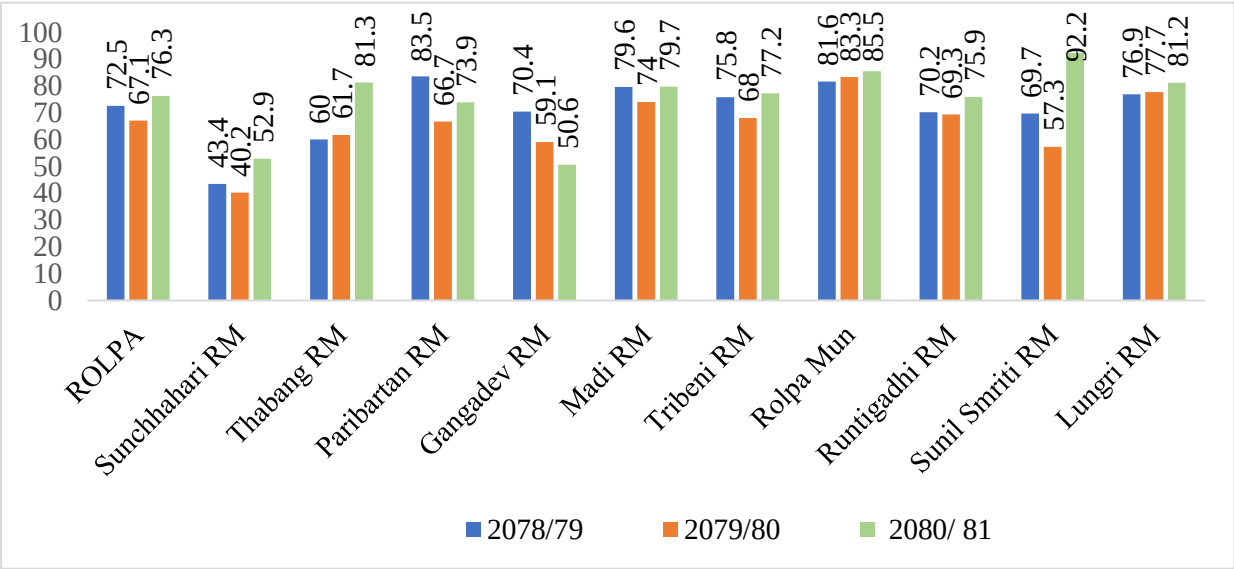
Name of LLG	Fiscal year 2078/79		Fiscal year 2079/80		Fiscal year 2080/81	
	Maternal death	VA done	Maternal death	VA done	Maternal death	VA done
Rolpa Mun	1	1	0		0	
Sunchhahari	0		1	1	0	
Thawang	0		0		0	
Paribartan	0		0		0	
Sukidaha	0		0		0	
Madi	1	1	1	1	0	
Tribeni	0		0		0	
Runtigadhi	1	1	1	1	0	
Sunilsmriti	0		1	1	0	
Lungri	0		0		0	
Total	**3**	**3**	**4**	**4**	**0**	

Maternal and Child Health Service Sites in Rolpa

Service Sites	Fiscal Year		
	2078/79	2079/80	2080/81
Number of CEOC Sites	1	1	1
Number of Functional BEOC Sites	2	2	2
Number of Birthing Centers	52	53	58

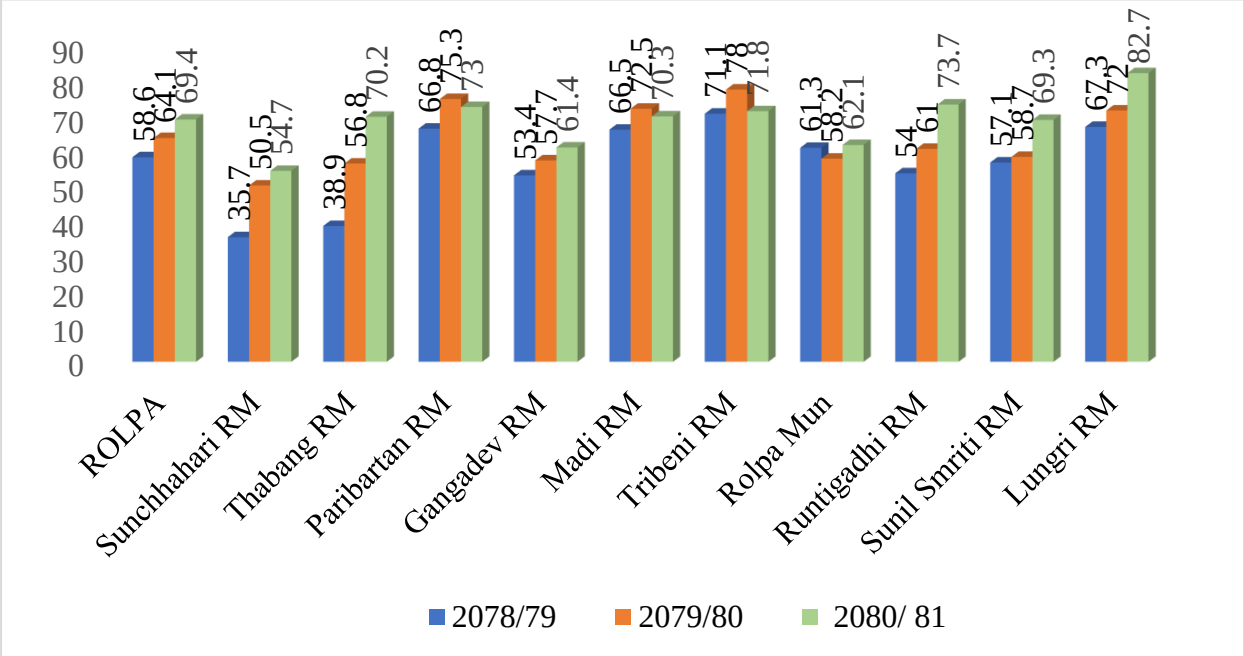
Major Indicators of Maternal and Child Health Program

Percentage of First ANC visit as per protocal



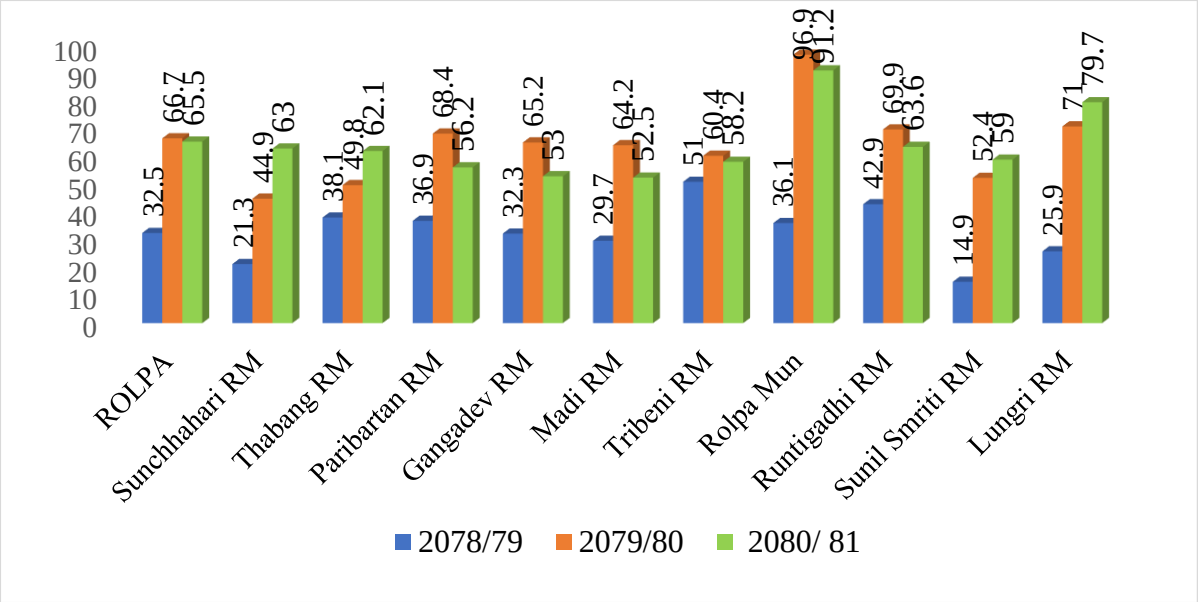
Above bar diagram shows that the first ANC visit percentage as per protocal has been increasing trend (67.1%-76.3%) in fiscal year 2080/81 than previous fiscal year in Rolpa district. All of the palikas first ANC visit percentage as per protocal has been increasing trend except Gangadev RM.

Percentage of Four ANC visit as per protocal



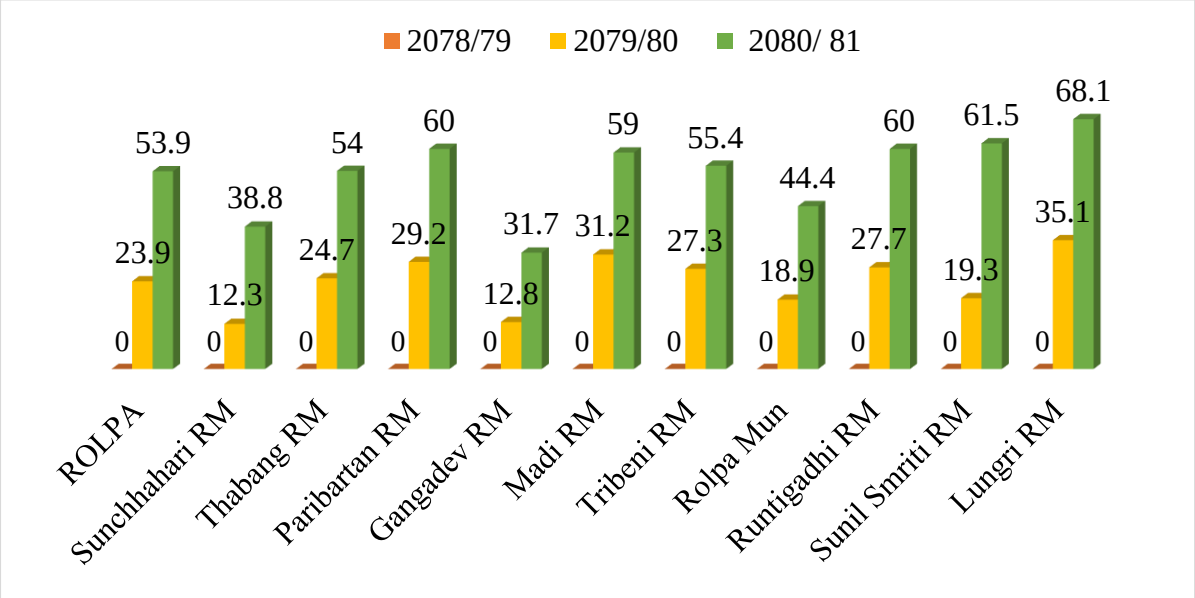
Above bar diagram shows that the four ANC visit as per protocal percentage has been increasing trend in fiscal year 2080/81 from previous fiscal year in Rolpa district along with all palikas.

Percentage of Institutional Delivery 2080/81



Above figure shows that the institutional delivery percentage of the Rolpa district has been decreased in fiscal year 2080/81 than FY 2079/80. Similarly, Sunchhahari RM, Thawang RM and Lungri RM of Institutional delivery has been increased in last fiscal year and other seven palikas institutional delivery has been decreasing line.

Percentage of 8 ANC checkup as per protocals in Rolpa



Above bar diagram shows that the Percentage of 8 ANC checkup as per protocals in Rolpa has been highly increasing trend (23.9 to 53.9%). Similarly, all palikas of Percentage of 8 ANC checkup as per protocals has been highly increased in last fiscal year than FY 2079/80.

Full Institutional Delivey Declaration wards in Rolpa

Name of LLG	Total No of Wards	Remarks
Rolpa Municipality	4	(Ward no. 4, 5, 6, 8)
Sunchhahari RM	0	
Thawang RM	0	
Paribartan RM	1	(Ward no. 1)
Gangadev RM	0	
Madi RM	0	
Tribeni RM	4	(Ward no. 2, 3, 4, 5)
Runtigadhi RM	2	(Ward no. 5, 9)
Sunilsmriti RM	3	(Ward no. 1, 2, 6)
Lungri RM	4	(Ward no. 2, 5, 6, 7)
Total Wards	**18**	

Above table shows that, the 18 wards were declared full institutional delivery in rolpa district, there were no any deliveries at home. However, few palikas yet to be started the full institutional delivey sites.

Major Indicators of Maternal and New Born Health:

Indicators	Fiscal Year		
	2078/79	2079/80	2080/81
% of pregnant women who had atleast one ANC checkup	85.2	91.3	92.3
% of pregnant women who had first ANC checkup as protocol	72.5	67.1	76.3
% of pregnant women who had four ANC checkup as per protocol	58.6	64.1	69.4
% of Instutional deliveries	32.5	66.7	65.5
% of Institutional Deliveries by SBA trained ANM	24.6	41.9	46.2
% of Institutional Deliveries by HWs other than SBA and SHP	27.1	20.2	16.2
% of Instutional deliveries under 20 years	0	18.3	19.4
Total Number of Caesarean Section	56	118	75
% of deliveries by Caesarean Section	1	2.2	1.6
% of women who received PNC within 24 hours of delivery	60.3	66.3	66.3
% of women who had 3 PNC checkup as per protocal	60.5	67.4	71.3
% of neonates who received 4 PNC checkup as per protocol	0	48.5	62
No. of home deliveries	245	127	86
No. of Maternal Death	3	4	0

No. of Neonatal Death	30	20	4
No. of Still Birth	33	45	40

ANC 1st visit as percent of ELB is 76.3% in FY 2080/81, which was increased as compared to previous FY 2079/80. However, the fourth ANC visit has increased to 69.4% as compared to previous FY. Institutional deliveries percentage by SBA trained ANM has significantly increased to 46.2 from 41.2% in last fiscal year 2080/81 as compared to fiscal year 2079/80. Total caesarian deliveries have slightly decreased in FY 2080/81 as compared to FY 2079/80 in Rolpa district.

Other indicators such as PNC 1st visit is constant as comparison to last FY, and four PNC visit as per protocol is in increasing trend since last three FY. Furthermore, five maternal deaths were reported during last FY and no any maternal death has been reported.

Safe Abortion Services (Numbers) in FY 2080/81

Fiscal Year	Aged <20 years		Aged ≥20 years	
	Medical	Surgical	Medical	Surgical
2078/79	63	8	717	52
2079/80	69	11	805	84
2080/81	49	3	848	43

Above table shows, that the safe abortion service of under 20 years in number is decresing trend in fiscal year 2080/81 as compare to FY 2079/80 where as increasing number of more than 20 years' women got safe abortion service. Altogether, 47 medical abortion sites in the Rolpa district.

Blood transfusion throughout district from Blood Transfusion Center, Rolpa during FY 2080/81

Clients From	Total no. of clients received blood	Remarks
Rolpa Municipality	60	
Sunchhahari RM	0	
Thawang RM	3	
Paribartan RM	17	
Gangadev RM	1	
Madi RM	13	
Tribeni RM	0	
Runtigadhi RM	0	
Sunilsmriti RM	0	
Lungri RM	2	
Other District	5	(Clients from Rukum purwa)
Total	**101**	

Blood transfusion services is provided by Nepal Redcross Society in collaboration with Rolpa Hospital since 2079/4/18. Lumbini Province government provides reimbursement amount to Nepal Redcross Society, Blood transfusion center for blood transfusion among maternal cases, so it is free of cost for those clients.

Total RUSG Sites and Service providers in Rolpa district

S.N.	Organisation	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			0
10	Lungri RM	Wadachour HP	Sunita Roka Chhetri	1
Total RUSG Sites				**12**

Major Activities carried out in 2080/81

- Purchase and supply of essential commodities to birthing center for Quality Improvement
- One-day orientation done to nursing staffs about Antishock garmants and its disrtibution to HF
- ANC to PNC Continuum of care and PNC home visit program
- MPDSR orientation to the MPDSR stakeholders for LLG and HF Level staffs including others
- Onsite coaching and mentoring, Onsite coaching and orientation for Pelvic Organ Prolapse management
- 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 viz; SBA, RUSG, CAC etc
- Community awareness activities to quality utilization of birthing center and services
- Done two episode of Reproductive Health Coordination Committee (RHCC) meeting
- Value clearification and attitude transformation orientation for Safe Abortion Services providers of ASRH program
- RMNCAH program orientation and update
- Referal mechanism strengthening program to the delivery service providers

Reproductive Health Morbidity Service data in district FY 2080/81

Uterine Cervical Cancer	HPV DNA, VIA and Pap Smear & Others	
	Screened	Positive
Number of female age group 30-49 yrs	866	0
Number of female >50yrs	306	0

Number of Ablative Treated	1		0	
Number of Colposcopy conducted	0		0	
Breast Cancer	**< 40 yrs**		**40-70 yrs**	**> 70 yrs**
Screened	673		443	47
Suspected	3		0	0
Obstetric Fistula				
Screened	668	Referred		36
Suspected	0	Surgery done		0
Uterine Prolapse (No. of women)				
Screened		1781		
Diagnosed witth prolapsed	Stage 1 & 2	216		
	Stage 3	189		
	Stage 4	26		
Inserted Ring Pessary		264		
Number of refered women		41		
Treated with surgery		141		

Above table shows that the number of female more then 30 years' age group screened of uterine cervical cancer ware 866 and got zero positive cases in last fiscal year. Similarly, breast cancer screening done from more than 40 years' age group of women and got only 3 cases has been suspected in last fiscal year. 1781 women has done the screen for uterine prolapse where 216 women have got first and second stage of uterine prolapse, 189 women have got third stage of uterine prolapse and 26 women have got 4 stage of uterine prolapse in last fiscal year. Similarly, 264 women treated by Ring Pessary, 41 women reffered to higher center and 141 women have done surgery for uterine prolapse.

Issues/Challenges, Recommendations and Responsibilities

Issues/Challenges	Recommendations	Responsibilities
Inadequate supply of logistics including power supply at Birthing Centers	Supply of adequate logistics (Equipments and Materials)	LLG
Less no. of SBA nurse and SBA delivery	Provide SBA training to Nurse working in birthing sites	HTC
Inadequate Health workforce (ANMs) at Birthing centers	Ensure 24 hrs. availability of adequate nursing staffs 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 -Run innovative programmes to encourage delivery at birthing centers	HF, LLG
Poor referral practice	Develop a referral guideline that includes provisions for referral forms, as well as communication and feedback mechanisms.	HF, LLG

2.5. FAMILY PLANNING AND REPRODUCTIVE HEALTH

Family Planning (FP) has been enshrined as a fundamental right in the constitution and included in the basic health service package under the Public Health Service Act 20751. In addition, the Safe Motherhood and Reproductive Health Act 2075, Safe Motherhood and Reproductive Health Regulation 2077, 5th National Plan (2076/77-2080/81) as well as Safe Motherhood and Newborn 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 SDG targets. Efforts are directed towards reducing contraceptive discontinuation, scaling up successful innovations, generating evidence, and linking FP services with delivery and demand generation interventions. FP information and services are disseminated through government channels, social marketing, non-government organizations (NGOs), and the private sector. 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 clinics, pharmacies, and hospitals also contribute to the comprehensive availability of FP services.

Lumbini province is also committed for improving equitable and right 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 outlet and by coordinating with local level governments. A number of policies and strategies in the province, such as the provincial health policy 2077, the first five-year periodic plan and the province's commitment to the SDGs, create a favorable policy environment for family planning programs.

Main Objective:

To improve the health status of all people through informed choice on accessing and utilizing client-centered quality voluntary FP services.

The specific objectives are as follows:

- To increase access to and the use of quality family planning services that is safe, effective and acceptable to individuals and couples. A special focus is on increasing access in rural and remote places and to poor, Dalit and other marginalized people with high-unmet needs and to postpartum and post-abortion women, the wives of labor migrants and adolescents.
- To increase and sustain contraceptive use, and reduce unmet need for family planning, unintended pregnancies and contraception discontinuation
- To create an enabling environment for increasing access to quality family planning services to men and women including adolescents.
- To increase the demand for family planning services by implementing strategic behavior change communication activities.

Policies and Strategic areas for FP

- Enabling environment: Strengthen the enabling environment for FP

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

SDG targets and indicators

Target and Indicators	2015	2019	2022	2025	2030	Source
Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods	66	71	74	76	80	NDHS, NMICS
Contraceptive prevalence rate (CPR) (modern methods) (%)	47.1	52	53	56	60	
Total Fertility Rate (TFR) (births per women aged 15-49 years)	2.3	2.1	2.1	2.1	2.1	
Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group	71	56	51	43	30	

Service Outlets of Family Planning Program

Indicators	Fiscal Years		
	2078/79	2079/80	2080/81
Number of Functional IUCD Sites	25	25	38
Number of Functional Implant Sites	45	46	59
Number of IUCD and Implant both Sites	23	24	36
Number of VSC Sites (Mobile camp)	7	7	10

As shown in above table, number of Long Acting Family Planning service sites for IUCD and Implant site increased in FY 2080/81 as compared to last FYs. Currently, there are 38 functional IUCD sites and 59 functional Implant sites. Thirty-six HFs have listed as availability of six FP methods round the year including Sayana press. VSC camp was conducted in ten startegic locations of district during FY 2080/81.

Major Indicators:

Indicators	Fiscal Years		
	2078/79	2079/80	2080/81
CPR ,Unadjusted, WRA	34.7	32.7	32.3
Percentage of modern contraceptives new Acceptors among WRA	11.8	9.3	7.8

Percentage of PP mothers using modern contraceptives method	0.06	17.7	18.6
VSC Cases	46	59	188

New acceptors are defined as the number of WRA who adopted any one FP method for the first time in their life. New acceptor as % of WRA was decreased as last FY, and CPR is slightly in decresing trends.

Age and sex wise distribution of VSC Cases of Rolpa district (FY 2080/81)

LLG Name	23-30 yrs		31-40 yrs		41-49 yrs		More the 50 yrs		Total	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
Sunchhahari	0	0	4	2	0	4	0	1	4	7
Thabang	3	1	12	2	2	2	0	1	17	6
Paribartan	0	0	4	8	1	2	0	0	5	10
Gangadev	4	2	4	5	0	0	0	0	5	10
Madi	5	1	20	2	0	0	0	0	25	3
Tribeni	5	0	6	9	2	2	0	0	13	11
Rolpa	0	1	7	10	0	3	0	1	7	15
Runtigadhi	4	0	14	2	1	1	0	0	19	3
Sunilsmriti	1	0	9	1	0	0	0	0	10	1
Lungri	1	3	2	10	0	1	0	0	3	14
Total	**23**	**8**	**82**	**51**	**6**	**15**	**0**	**3**	**111**	**77**

Above table shows that the age and sex wise distribution of VSC cases within the camp setting in Rolpa district during the fiscal year 2080/81 where female clients for minilap were 111 and male clients vasectomy were 77 and total case were 188 of all palikas. VSC cases have increased as compared to last FY, 144 % achievemet made in FP Camp for VSC cases as per target provided by DoHS/FWD. (Total target of Rolpa district was 130)

Major Activities carried out in FY 2080/81

- Provision of regular comprehensive FP service including post-partum and post abortion FP services
- Provision of long acting reversible services (LARCs)
- Introduce and availability of emergency contraceptive pills (ECP) services through all public health facilities and FCHVs
- LARCs onsite coaching conducted resulting expansion of LARCs sites
- Pre -VSC Interaction programme of FCHVs and local stakeholders
- VSC camp conduction in different 10 sites
- Interaction program on FP in marginalized communities
- Monitoring and Supervision of FP and RH programs
- FP microplanning program for under served and hard to reach areas

Issues/Challenges, Recommendations and Responsibilities

Issues /Challenges	Recommendations	Responsibilities

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 report from private clinics in regular basis	HFs, 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 mobile camp only	Provide VSC service through district level Institution	HO, MOH, HTC
Seasonal demand of FP during festival (as the periodic out-migrants return back to their home during festival time)	Prepare FCHVs to address the seasonal demand of FP	LLG, HF

2.6. ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH

Adolescents aged 10 to 19 make up 24% (6.4 million) of Nepal's population, with 17% of girls aged 15-19 already mothers or pregnant. Only 14.2% of currently married adolescents use modern contraceptives. Nepal, a pioneer in South Asia, endorsed its first National Adolescent Health and Development (NAHD) Strategy in 2056/57 (2000), later revised in 2074/75 (2018) to address evolving adolescent issues. GoN has the national strategy for adolescent health and strategy to enable and prioritize adolescent health issues including sexual and reproductive health.

Adolescent friendly health facility implementation guideline, 2079 was developed and endorsed. As of 2079/80, nearly 287 health facilities are certified as adolescent friendly service sites throughout country. Declining trend in new users of FP services (both male and female) and safe abortion services have reduced. In FY 2080/81, there was a slight increase in number of adolescent utilizing four ANC visits as per protocol.

Vision:

To enable all adolescents to be healthy, happy, competent and responsible

Mission:

Optimum use of the available methods and establishing strong bond between the concerned parties and developing 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 life styles 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 adolescence issues through BCC campaigns and at national, provincial and community levels through FCHVs and mother groups.

Targets:

- To make all health facilities as adolescent friendly as per the envision of National Health policy (2019) and NHSS (2016-2021),
- To ensure universal access to ASRH services, the Nepal Health Sector Strategy Implementation Plan (2016-2021) aims to:

  -scale up Adolescent Friendly Service (AFS) to all health facilities;

-behavioral skill focused ASRH training to 5,000 Health Service Providers and

-more than 100 health facilities to be certified with quality AFS by 2021

The program aims to reduce the adolescent fertility rate (AFR) by improving access to family planning services and information.

Strategic Principles and Direction

- Participation and leaderships of adolescent
- Equality and equity
- Right with responsibility
- Strategies partnership
- Role of central, province and local government

Key Intervention Area for ASRH Program

- School health nurse program
- ASRH site certification
- Capacity building of health workers
- Scale up and strengthen health facilities for Adolescent Friendly Services (AFS)
- Establishment of Adolescent Friendly Information Corners (AFICs) in schools.
- ASRH training to health workers
- Menstrual Hygiene management (MHM)
- Comprehensive Sexuality Education (CSE) in School
- Advocacy

The criteria of adolescent-friendly services (AFS) include the availability of trained staffs 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.

School Health Nurse (SHN) Program in district

The main goal of the School Health Nurse Program is to develop 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 healthy school environment
- Improve health and nutrition behaviours and habits
- Improve and strengthen community support system, and policy environment.

Altogether 14 School Health Nurse is currently working in different schools of Rolpa district, whereas Triveni RM, Rolpa municipality and Thawang RM has 12, 1 and 1 SHN respectively. SHN major responsibilities includes; preventive and promotive activities, conduction of public health campaign, basic first aid services, school health and nutrition services and activities etc.

Implementation Status of ASRH Program in Rolpa

Initially, the Rolpa district identified 13 Health Facilities for the ASRH programme in FY 2069/70. Now, altogether 52 health facilities in the district were listed as AFS site for the provision of quality Adolescent Friendly Health Services. Furthermore, to ensure quality and sustainability of ASRH program, the remaing HFs are going on the process of listing as AFS site and way of certification. Altogether 19 Health Facilities Certified as Adolescent Friendly Service Sites from DoHS and as well as respective local level government.

ASRH Certified health facilities throughout district

Name of LLG	No of AFS Certified HF	Name of HF
Rolpa Municipality	6	Khumel, Libang, Kotgaun, Jankot, Dhawang, Jedwaang HP
Sunchhahari RM	1	Powang HP
Thawang RM	1	Thawang Basic Hospital
Paribartan RM	1	Rangkot HP
Gangadev RM	1	Jinawang HP
Madi RM	1	Ghartigau HP
Tribeni RM	2	Nuwaagaun, Nerpa HP
Runtigadhi RM	0	
Sunilsmriti RM	3	Sulichaur PHC, Ghodagau, Khungri HP
Lungri RM	3	Haarjang, Gumchal, Badachaur HP
Total HF	**19**	

Major Achievements (Three years' trends of ASRH Program)

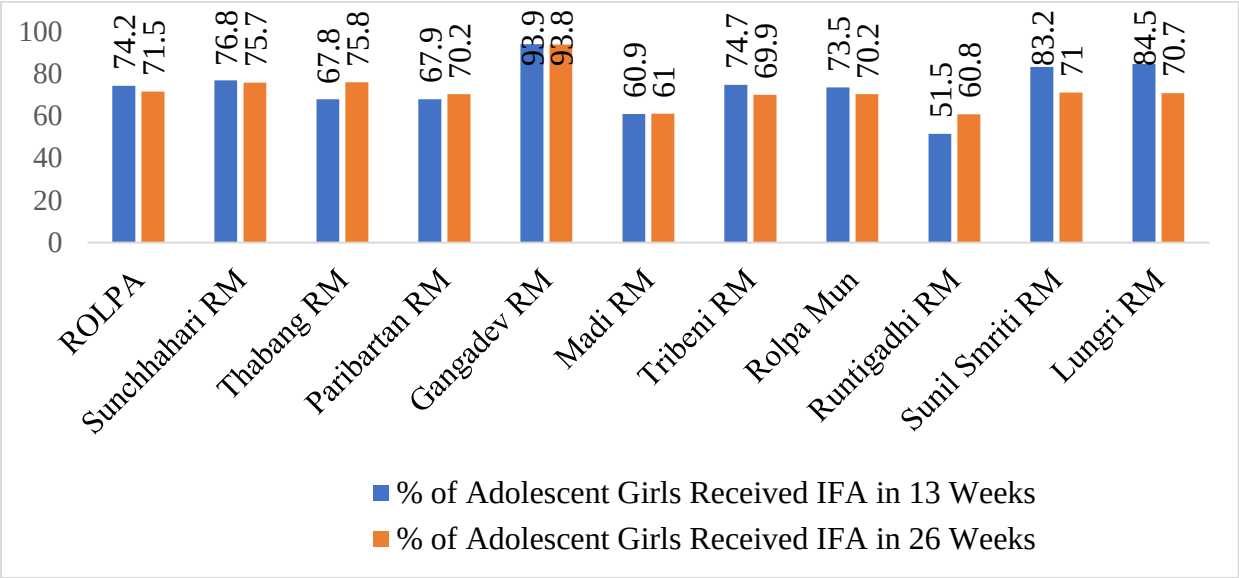
Indicators	Fiscal Years		
	2078/79	2079/80	2080/81
Total number adolescent girl received ANC service within 12 weeks (under 20 years)	949	713	696
Total number adolescent girl received 4 ANC service (under 20 years)	582	531	553
Total number adolescent girl received 8 ANC service (under 20 years)	0	196	415
Total number of Institutional Delivery (under 20 years)	0	660	612
Percentage of delivery below 20 yrs of age among total institutional delivery	0	18.3	19.4
Total number adolescent girl safe abortion cases (Medical + Surgical) (under 20 years)	71	80	52
Depo User (under 20 years)	780	433	289
Pills User (under 20 years)	366	124	111
Implant User (under 20 years)	23	36	50
IUCD User (under 20 years)	1	1	0

Adolescents Girls Iron Folic Acid Supplementation

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 Anaemia (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 bi-annually 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.

Percentage of Palikawise IFA Distribution Status



Above the bar diagram shows that the overall IFA distribution status of district has been decresing in 26 weeks than 13 weeks where 74.2% in 13 weeks and 71.5% in 26 week. Sunchhahari, Triveni, Rolpa, Sunilsmriti, Gangadev and Lungri LLG has been decresing the percentage of IFA distribution status in 26 weeks than 13 weeks. Thabang, Paribartan, and Madi and Runtigadhi has been increasing in 26 weeks than 13 weeks.

Iron Folic Acid Received by Adolescent Girls of age 10-19 yrs

Period	Distribution Site			Coverage %	Target Population
	School	Health Facility	FCHV		
13 Weeks	19195	41	256	74.2	26258
26 Weeks	18556	43	177	71.5	

Adolescents Girls Anemia Status Assessment (Hameglobin test) Program

Local Level	Total school	Total no. of students tested	Total no. anaemic	Anaemic adolescent girl

	involved		students	(%)
Gangadev RM	2	313	93	29.71
Lungri RM	2	493	130	26.37
Madi RM	2	339	120	35.40
Paribartan RM	2	340	85	25.00
Rolpa Mun	2	984	530	53.86
Runtigadhi RM	2	295	71	24.07
Sunchhahari RM	2	391	28	7.16
Sunilsmirti RM	2	218	97	44.50
Thabang RM	2	387	31	8.01
Tribeni RM	2	557	278	49.91
Total	**20**	**4317**	**1463**	**33.89**

Altogether 33.89 % of adolecsnts girls are found anamic i.e. the blood hameglobin level is less than 11.9 gm/dl.

Major Activities conducted in FY 2080/81

- Iron Folic Acid supplementation to the adolescent girls
- Performed adolescents girls anemia status assessment (hameglobin test) among 20 community school representing 2 school from each LLG
- Whole site orientation regarding Adolescent Program Implementation Guideline to 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 Health facility incharge
- Program orientation to local stakeholders including HFOMC members, FCHVs in program HFs
- Community awareness activities through existing structures
- Conducted bi-annual ASRH review meetings at district level
- School health program by school health nurse
- Monitoring and supportive supervision of ASRH program

Issues/Challenges, Recommendations and Responsibities

Issues/Challenges	Recommendations	Responsibilities
High prevalence of early marriage and teenage pregnancy	Intensify community awareness activities and effectively implement the law	MoH,Palicy makers, LLG and HO
Timing is not friendly for students to come in health facility for AFHS	Specify 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	Provision of counselling training	FWD, MoH, HO, EDPs

staffs for adolescent and youth counseling	to HFs, preferably from both male and female gender	
Lack of community awareness and importance on adolescent sexual and reproductive health	Needed to expand ASRH program up to community level Orientation needed for guardian	HO, HF, EDPs
Newly Constructed HF Building have no Space for AFS Corner	Design of AFS room in newly constructed health facility building	MD/DUDBC/LLG
Poor coverage/ performance of the IFA distribitution program for adoleascent girls	Program needs to link with School Health and Nutrition program and implement jointly with focal teacher and health workers with certain incentives	MoSD/MOH/HD/HO/LLG

2.7. PRIMARY HEALTH CARE OUTREACH CLINIC

Established in 2051 (1994), Primary Health Care Outreach Clinics (PHC/ORC) aim to enhance community access to essential health services such as family planning, child health, and safe motherhood. Operating as extensions of PHCCs and health posts, these clinics are conducted monthly at fixed locations, dates, and times, within a half-hour walking distance for their catchment populations. ANMs, paramedics, FCHVs, and local NGOs collaborate to provide basicprimary health care services based on local needs.

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

Safe Motherhood & Newborn Care • Antenatal, postnatal, and newborn care • Iron distribution • Referral if danger signs identified **Family Planning** • DMPA, (Depo-Provera) pills and condom • Monitoring of continuous users • Education and counseling on FP methods and emergency contraception • Counseling and referral for IUCD, implant and VSC service • Tracing defaulter	**Child Health** • Growth monitoring of under 2 years' children • Pneumonia/Diarrhoea treatment **Health Education and Counseling** • Family planning • Maternal and newborn care • Child health • STI, HIV/AIDS • Adolescents' sexual and reproductive health **First aid treatment** • Minor treatment and referral for complicated cases

Major Indicators of PHC/ORC Program

Indicators	Fiscal Years		
	2078/79	2079/80	2080/81
Total no. of Clinics Planned	2128	2068	2136
PHC/ORC conducted (%)	95.86	97.29	98.08
Total no. of client received available service	37656	43766	49892
Average number of people served per clinic	18.5	21.8	23.8

Above table shows that, total number of clinics were 2136 in last fiscal year which is increasing trend than FY 2079/80. Similarly, PHC/ORC session conducted percentage also increasing trend (97.29 to 98.08%) which is good. Average number of people served per clinic was 23.8 which is also increasing trend.

Issues/Challenges, Recommendations and Responsibilities:

Issues/Challenges	Recommendations	Responsibilities
Congested room/corner for PHC ORC	Strengthen PHC/ORC committee and select the proper place. Local resource mobilization to strengthen PHC/ORC	HO, HF, HFOMC, HMG, R/M
Some PHC/ORC are not proper conducted as per guideline	Decide whether PHC/ORC clinics are at appropriate place of the community. Ensure community participation and ownership in PHC/ORC conduction as per local need.	HFOMC, HF, R/M
Inadequate human resource mobilization to conduct the clinics	Mobilize AHWs and ANMs compulsory to every clinic.	HO, HF, HFOMC, R/M
Lack of field allowance to additional staff mobilization	Endorse a policy to provide allowance for field staffs	FWD, DoHS, R/M

CHAPTER 3

EPIDEMIOLOGY AND DISEASE CONTROL

3.1. TUBERCULOSIS

Tuberculosis (TB) is a significant public health issue in Nepal, being a leading cause of global mortality. Caused by Mycobacterium tuberculosis, it primarily affects the lungs but can also manifest in other organs. With nearly a quarter of the global population infected, TB is 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 currentTB epidemic status, progress in response efforts, and the impact of COVID-19, drawing on data from various sources, including NTCC, HMIS, NTP MIS and WHO country profiles.

TB Burden Estimate

Based on the National TB prevalence survey report 2076(2020), TB prevalence in Nepal is 1.8 times, incidence is 1.6 times and TB mortality is 3.1 times higher than the previous estimates. Though the incidence is higher than the previous estimates, the incidence rate is declining by 3% annually. An assumption of a 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%/year growth in Gross National Income (GNI)/capita.In 2078 (2022), Nepal grapples with a TB burden, estimating 70,000 total cases at an incidence rate of 229 per 100,000 populations. HIV-related TB stands at 540 cases, with an incidence rate of 1.8 per 100,000, while drug-resistant TB, including Multi Drug Resistance/Rifampicin Resistant (MDR/RR)-TB, affects 2,900 individuals at a rate of 9.5 per 100,000. The mortality toll is significant, with 18,000 HIV-negative TB deaths (mortality rate: 58 per 100,000) and 220 HIVpositiveTB deaths (mortality rate: 0.71 per 100,000).

Year	Incidence (all forms)	Prevalence (all forms)	Mortality (HIV Neg. & Pos.)
2075 (2018) New estimates	69,000 (245 per 100k)	1,17,000 (416 per 100k)	17,003 (9,000-26,000)
2075 (2018) Prior estimates	42,000 (151 per 100k)	60,000 (215 per 100k)	5,500 (3,900 - 7,400)
Revised burden, higher by:	1.6	1.8	3.1

Table: Comparison between the pre-and post-survey TB burden, 2075 (2018)

Guiding Document: National Strategic Plan 2079/80- 2083/84 (2021/22-2025/26) for TB

Vision :TB Free Nepal
Goal: Nepal has set a goal to decrease incidence rate from 238 in 2020/21 to 181 per 100,000 population by 2025/26; decrease mortality rate from 58 in 2020/21 to 23 per 100,000 by

2025/26; end 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 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; effectuate the TB services and support by increasing the 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

Global Strategy: End TB Strategy 2015 to 2035

Vision: A world Free of TB; Zero deaths, disease and suffering due to TB

Goal: End the Global TB Epidemic

MILESTONES FOR 2025:

1. 75% reduction in TB deaths (compared with 2015)
2. 50% reduction in TB incidence rate (less than 55 TB cases per 100,000 population)
3. No affected families facing catastrophic costs due to TB

TARGETS FOR 2035:

1. 95% reduction in TB deaths (compared with 2015)
2. 90% reduction in TB incidence rate (less than 10 TB cases per 100,000 population)
3. No affected families facing catastrophic costs due to TB

The End TB Strategy was unanimously endorsed by the World Health Assembly in 2014. Its three overarching indicators are i) the number of TB deaths per year, ii) TB incidence rate per year, and iii) the percentage of TB-affected households that experience catastrophic costs as a result of TB. These indicators have related targets for 2030 and 2035.

Principles:

• Government stewardship and accountability, with monitoring and evaluation;
• Strong coalitions with civil society organizations and communities;
• The protection and promotion of human rights, ethics and equity; and
• The adaptation of the strategy and targets at country levels, with global collaboration

The strategy's components (three pillars) and related strategies are as follows:

1. **Integrated, patient-centered care and prevention:**
   - Early diagnosis of TB including universal drug-susceptibility testing, and systematic screening of contacts and high-risk groups
   - Treatment of all people with TB including drug-resistant TB
   - Collaborative TB/HIV activities and the management of co-morbidities
   - The preventive treatment of persons at high risk, and vaccination against TB

2. Bold policies and supportive systems:

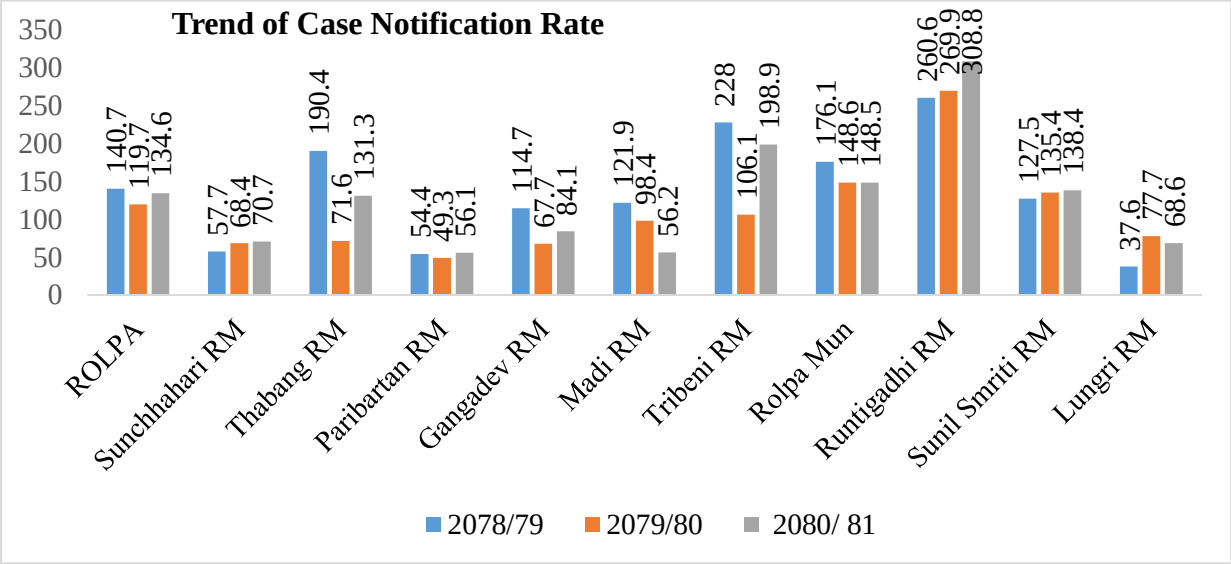
- Political commitment with adequate resources for TB care and prevention
- The engagement of communities, civil society organizations, and public and private care Providers
- Universal health coverage policy and regulatory frameworks for case notification, vital registration, quality and rational use of medicines, and infection control
- Social protection, poverty alleviation and actions on other determinants of TB

3. Intensified research and innovation:

- The discovery, development and rapid uptake of new tools, interventions and strategies
- Research to optimize implementation and impact, and promote innovations

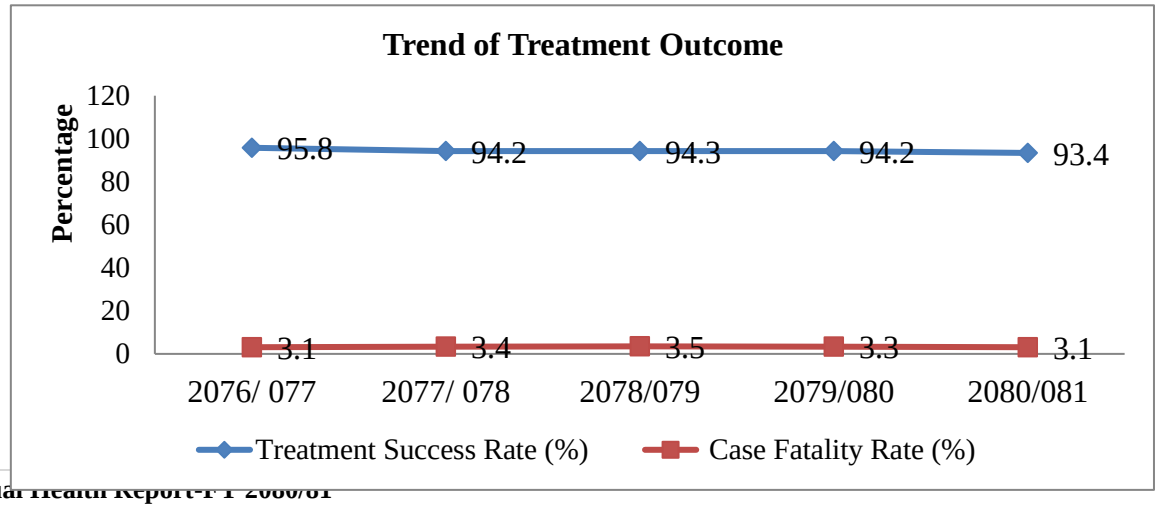
Status of the Tuberculosis program in Rolpa

Case Notification Rate of Rolpa (CNR)

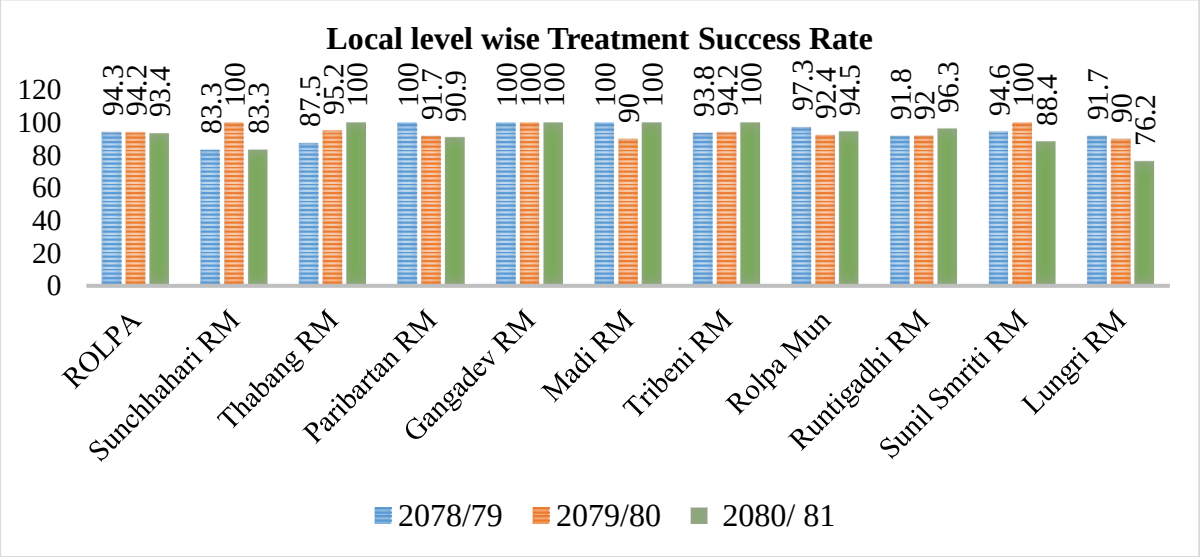


Altogether, 312 all forms of TB were notified during 2080/81, out of which, 264 were new cases. Among them 164 were bacteriologically confirmed new pulmonary cases (PBC), 32 cases were clinically diagnosed new pulmonary cases and 68 were new extra-pulmonary cases. The case notification rate for all forms of TB and new and relapse PBC cases have been slightly increased in Rolpa compared to fiscal year 2079/80, which is shown in the figures. The total 15 cases has been increased compare to FY2079/80

Treatment Outcomes

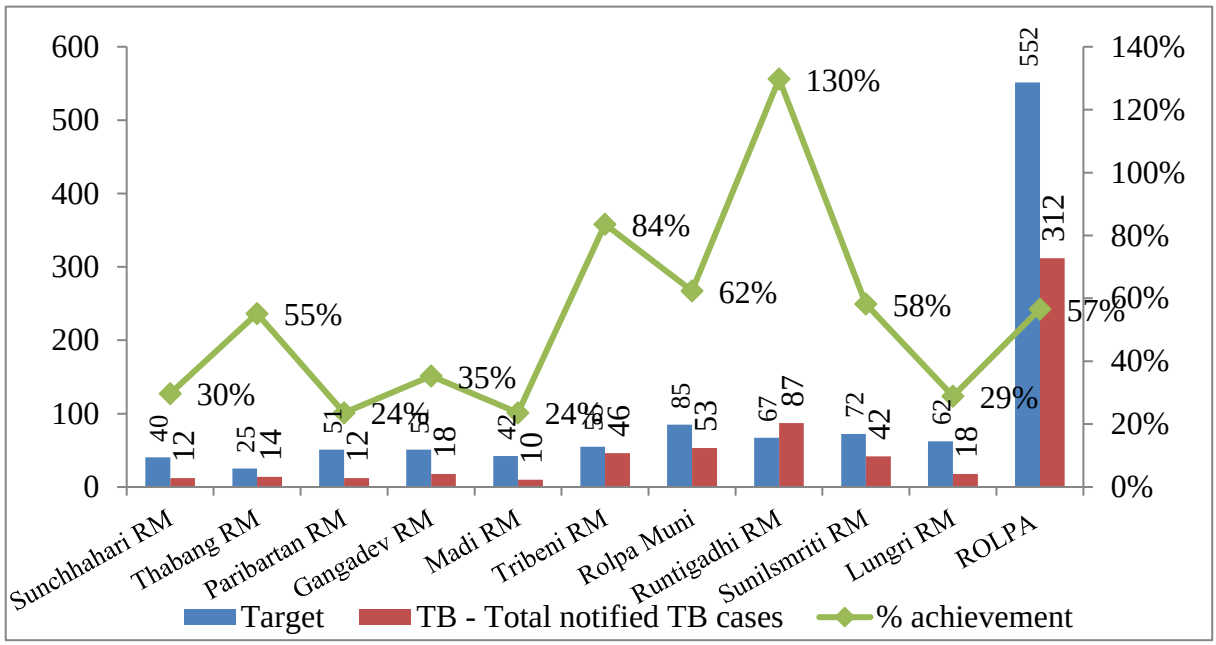


Treatment success rate and case fatality rate is consistently decreasing from last three fiscal years by very little percentage with the maintaining of global treatment success rate and case fatality rate, >90% and <5% respectively. Compare with financial year 2079/80 to 2080/81 treatment success rate is decreased by 0.8% and case fatality decreased by 0.2%. The treatment success rate of Lungri RM, Sunchhahari RM, and Sunilsmriti RM was below 90%, while other local levels had rates above 90%



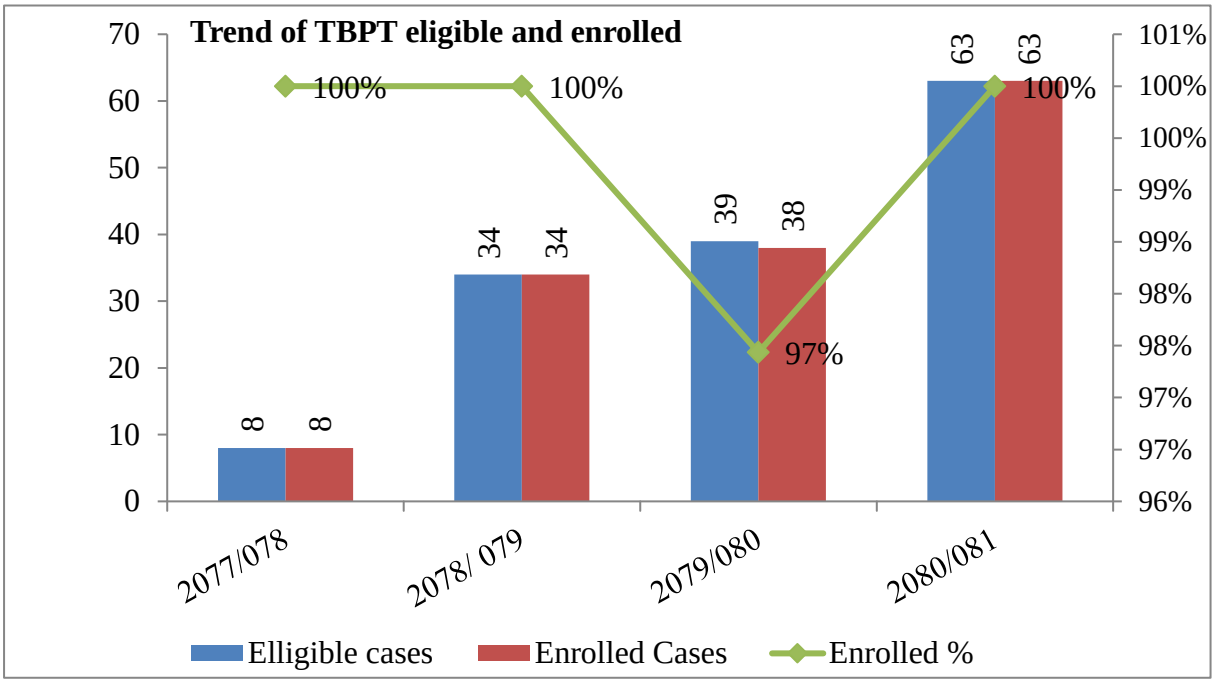
Target Vs achievement of TB cases of Rolpa (FY 2080/81)

According to the graph only 57% of the total target cases has notified in fiscal years 2080/81. The Rolpa district has 552 TB cases target but only 312 cases have been notified of TB cases. Most of the Local level has less than 50% cases have been notified compare to target cases.



Tuberculosis Preventive Therapy

This intervention will prevent peoplefrom developing active TB, who were infected by TB patients. The enrolment of children under five who were eligible for TB preventive therapy has been increasing over the last four fiscal years. One hundred percent of eligible children have been enrolled in TBPT according to the above chart.



Microscopy Centers/locations 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
Total			**10**

Major activities carried out in FY 2080/81

- World TB Day was celebrated for an entire week in Rolpawhich contributed 12 cases to district case notification through active case finding.
- 15 health workers were participated in TB Modular training from BHSC conducted in Health Office Rolpa.

- 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 in all Local Level
- Conducted Annual and semiannual review/cohort analysis meeting
- Conducted TB ACF in Meltakura, Jabang, Ghorneti BHSC, and Dubidanda HP and notified 6 cases including 1 DR cases.
- 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 hospital
- Nutrition allowance provided for TB relapse and new cases for poor person.
- Regular supply of medicine and commodities including laboratory supplies
- IEC/BCC messages production and broadcasting via local medias
- Onsite coaching, Supportive Supervision and Monitoring to improve the TB program

Issues/Challenges, Recommendations and Responsibilities:

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

3.2. LEPROSY ELIMINATION PROGRAM

Leprosy, or Hansen's disease, is caused by Mycobacteriumleprae, an acid-fast, rod-shaped bacillus. With ancient roots, it is likely transmitted through droplets during prolonged contact with untreated patients. Primarily affecting the skin, peripheral nerves, respiratory mucosa, and eyes, leprosy is curable. Early diagnosis and treatment in the initial stages can prevent disability. Historically associated with social stigma, GoN has been actively working to support individuals affected by leprosy since the year 1913/14 (1857).

Year BS (AD)	Milestones
1913/14 (1857)	Establishment of Khokana Leprosarium
2016/17 (1960)	Leprosy survey by Government of Nepal in collaboration with WHO
2022/23 (1966)	Pilot project to control leprosy launched with Dapsone monotherapy
2038/39 (1982)	Introduction of multi-drug therapy (MDT) in leprosy control programme
2043/44 (1987)	Integration of vertical leprosy control programme into general basic health services
2047/48 (1991)	National leprosy elimination goal set
2051/53 (1995)	Focal persons (TB and leprosy assistants [TLAs]) appointed for districts and regions
2052/53 (1996)	All 75 districts were brought into MDT programme
2055- 2057 (1999/2000–2001/02)	Two rounds of National Leprosy Elimination Campaign (NLEC) implemented
2064/65 (2008)	Intensive efforts made for achieving elimination at the national level
2065/66 (2009 and 2010)	Leprosy elimination achieved and declared at the national level
2067/68 (2011)	Developed and endorsed National Leprosy Strategy (2011–2015)
2068/69 (2012-2013)	Elimination sustained at national level and national guidelines, 2013 (2070) revised
2069/70 (2013-2014)	Mid-term evaluation of implementation of National Leprosy Strategy (2011-2015)
2070/71 (2014-2015)	Ministry of Health designated Leprosy Control Division as the Disability Focal Unit
2070/71-2074/75 (2015-2018)	Piloting of Leprosy Post Exposure Prophylaxis in Jhapa, Morang and Parsa
2073/74 (2017)	Policy, Strategy and 10 Years Action Plan on Disability Management (Prevention, Treatment and Rehabilitation) 2073-2082 developed and disseminated
2074 (2018)	National Leprosy Strategy 2073-2077 (2016-2020) developed and endorsed. Revised leprosy guideline in line with national leprosy strategy and global leprosy strategy.
2075/76 (2019)	In-depth Review of National Leprosy Programme and Envisioning Roadmap to Zero Leprosy
2076/77(2020)	Development of Leprosy Post Exposure Prophylaxis Guideline
2077/78 (2021)	Endorsement National Roadmap for Zero Leprosy-Nepal 2077/78-2087/88 (2021-2030) Endorsement of National Leprosy Strategy 2077/78 – 2081/82 (2021-2025)

Table: Milestones of National Leprosy Elimination Program of Nepal

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)

Guiding principles

- Stewardship and system strengthening

- Expedite the elimination process in high prevalence districts
- Collaboration, coordination and partnership
- Community involvement
- Integration, equity and social inclusion

Objectives:

1. To eliminate leprosy at the subnational level (province, district, local level)
2. To strengthen clinical case management at district and municipal levels and improve referral system.
3. To enhance capacity building through training of health staff particularly at the peripheral health facilities
4. To enhance prevention of leprosy
5. To reduction of stigma and discrimination
6. To strengthen leprosy surveillance system and regular monitoring, supervision, and n periodic evaluation at all level.
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 management, reporting and referral of cases from border areas.
10. To promote research and innovations

Targets of National Leprosy Strategy

S.N.	Targets	2019* (baseline)	2025
Target 1	Mapping of districts/ municipalities including human resources	√	Updated
Target 2	Number of municipalities with zero new child autochthonous cases over consecutive 5 years period	605**/753	700/753
Target 3	Number of municipalities with zero leprosy cases	65	377
Target 4	Number of annual new leprosy cases reduced to	3282	2462 (25 % reduction from baseline)
Target 5	Rate of new leprosy cases with G2D (per million population)	5.3	< 1
Target 6	New child leprosy case detection rate (per million child population)	30	< 6
Target 7	Number of child cases among new leprosy cases reduced to	260 (7.9 % child case proportion among new leprosy cases)	50(2% child case proportion among new leprosy cases)
Target 8	Number of child G2D among new child leprosy cases	2 of 260 new child cases	0

Target 9	Discriminatory laws	Discriminatory law exists	Zero discrimination as a result of no discriminatory laws and complaints reporting system in place
Target 10	Roll out of preventive chemoprophylaxis	-	50 % coverage among eligible contacts
Target 11	Household contact examination of an index case within 3 months of case detection	-	75 % of index case

* 2019 is taken as the baseline because of impact of COVID-19 pandemic on leprosy cases diagnosis & treatment.
** For baseline only one-year data of 2019 is taken due to unavailability of municipality level data of the past 5 years.

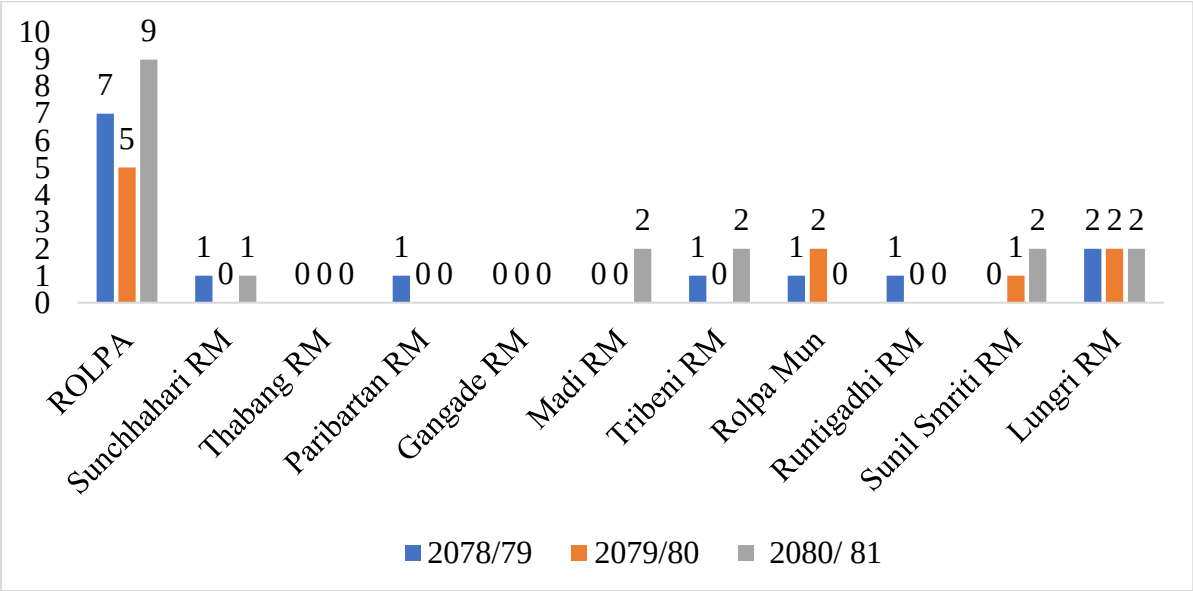
Achievement three years' trends (Rolpa)

Indicators	**Fiscal Years**		
	2078/ 79	**2079/80**	**2080/81**
Total Leprosy New cases	7	5	9
New case detection rate of leprosy	2.9	2.1	3.9
Prevalence of leprosy per 10,000 population	0.3	0.21	0.39
Percentage of new leprosy cases presenting with a grade-2-disability	0	0	11.1
Propertion of female cases among new cases detected	14.3	40	22.2
Propotion of children(0-14yrs) among new cases detected	0	0	0
Percentage of relapse cases of leprosy	0.78	0.66	0.71

Nepal has declared itself with the Leprosy elimination status in January 2010 and since than 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 populations) till now.

In the fiscal year 2080/81, the new case detection rate is 3.9 per 100000 populations which has increase than last year in Rolpa district. Along with, prevalence rate had increase to 0.39 in FY 2080/81 as compared to FY 2079/80. There are total 9 leprosy cases under treatment throughout the district in fiscal year 2080/81.

Distribution of Leprosy cases (3 years trend)



Above bar diagram shows that the distribution of Leprosy cases of three fiscal years where as overall cases in district has been increase in fiscal year 2080/81 than previous two years' trend. Nine cases have been found in last fiscal years. Lungri RM has 2 cases in three fiscal years and Thabang and Gangadev RM has no cases in three fiscal years.

Major activities carried out in FY 2080/81

- Family diagnosis of patients and their neighbors
- Contract tracing to the family member of leprosy cases.
- Transportation cost provided to RFT cases
- Conducted orientation program targeting lab person and health worker focusing in diagnosis, treatment and management cases.
- Regular supply of medicine and commodities
- Stakeholders meeting conducted in Sunilsmriti RM to increase access and utilization services.
- IEC/BCC intervention and world leprosy day celebration
- Supportive supervision and monitoring of the program

Issues/Challenges, Recommendations and Responsibilities

Issues/Challenges	Recommendations	Responsibilities
Difficulty in managing reaction and complicated leprosy cases	Number of referrals centers should be increased	DoHS/MoH
Lack of orientation towards health workers for diagnosis and treatment of leprosy cases	Mandatory to provide basic leprosy training to the newly recruited health workers	DoHS/MoH/PHD
Difficulties in diagnosis of new leprosy cases	Skin Screening camp should conduct with dermatologist in remote area.	PHD/MOH/CSSD

3.3. MALARIA CONTROL PROGRAM

Malaria is a mosquito-borne infectious disease that possess a public health challenge in Nepal. The disease is primarily transmitted to humans through the bites of infected female Anopheles mosquitoes. Malaria is endemic in certain parts of Nepal, with the Terai region (southern plains) being the most affected area. However, the cases have also been reported in the hilly and mountainous regions. Malaria in Nepal exhibits seasonality, with the peak transmission occurring before and after the rainy season. To better understand and combat malaria, Nepal has adopted a micro-stratification approach. Nepal's "malaria micro-stratification process" began at the district level in 2066/67 (2010). To enhance communitylevel risk stratification and accurately define the total population at risk, micro-stratification was performed at the ward level within LLGs.

Based on the recommendation by EDCD and TWG and 2068/69 (2012), 2072/73 (2016) and 2074/75 (2018) micro-stratification study the methodology used for micro-stratification includes recent data on malaria disease burden, coupled with spatial information on climate, ecology, key vector species, and vulnerability in terms of human population movement. Using this approach, the 2079/80 (2023) micro-stratification updated wards, categorizing them as high, moderate, low and no risk. While the Terai regions show low endemicity, upper hilly river valleys, previously categorized as 'No Malaria' risk, are now reporting increased infection rates. Despite this, the current stratification retains the same ward categories as the previous three years, with program activities directed accordingly, Notably, the concentration of malaria cases was primarily observed in Sudurpaschim and Karnali Provinces, encompassing all high-risk wards and 94% of moderate-risk wards. The remaining 6% of moderate-risk wards were identified in Lumbini Province.

According to Malaria micro-stratification 2021 total High risk ward and moderate risk wards are 22 and 69 respectively while no any wards of the Rolpa district exist with in above categories.

The aim of NMSP is to attain "Malaria Free Nepal by 2026".

National Malaria Strategic Plan (NMSP 2014 – 2025) which was developed in 2013 with pre-elimination focus was updated in 2021 based on the WHO Global Technical Strategy for malaria elimination 2016 – 2030 and framework for malaria elimination, federalization of the health system, disease epidemiology and midterm malaria program review-2017.Nepal is also part of the global E-2025 countries with aim to attain "Malaria Elimination in Nepal by 2025".

Vision: Malaria Elimination in Nepal by 2025

Mission: Ensure universal access to quality assured malaria services for prevention, diagnosis, treatment and prompt response in outbreak.

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

Objectives:

To ensure proportional and equitable access to quality assured diagnosis and treatment in health facilities as per federal structure and implement effective preventive measures to achieve malaria elimination.

The updated NMSP (2014-2025) will attain the elimination goals through the implementation of following five strategies:

- Strengthen surveillance and information system on malaria for effective decision making
- Ensure effective coverage of vector control interventions in malaria risk areas to reduce transmission.
- Ensure universal access to quality assured diagnosis and effective treatment for malaria, ensure government committed leadership and engage community for malaria elimination.

Malaria Control Program in Rolpa district:

Indicators (Number)		Fiscal Year		
		2078/79	**2079/80**	**2080/81**
Blood slide collection and RDT performed	ACD	14	58	131
	PCD	210	1068	2550
Total malaria positive cases		0	1	0
Malaria test positivity rate		0	0.09	0

Blood slide collection and Rapid Dignostic Test for malaria test is highly increased in FY 2080/81; No malaria cases has detected during the fiscal year 2080/81 in the district. However, one imported case was identified in Rapti Academy of Health Sciences Ghorai Dang.

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

Major Activities performed during FY 2080/81

- Sample collection of suspected malaria cases and test was done by rapid diagnostics test kits
- To conduct Case Base Investigation in positive cases area, Case-based treatment and referral
- Celebrated World Malaria Day on 25 April

Issues/Challenges, Recommendations and Responsibilities:

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

3.4: HIV/AIDS and STI

Nepal first identified a case of Human Immunodeficiency Virus (HIV) in 2044/45 (1988), prompting the development of National Policy on Acquired Immunodeficiency Syndrome (AIDS) and Sexually Transmitted Diseases (STDs) Control in 2052 (1995) The National Centre for AIDS & STD Control (NCASC) was established in 2050 B.S. to formalize the response against HIV and STIs control in Nepal. Recognizing the dynamic nature of the HIV epidemic, Nepal revised its initial policy and endorsed an updated version in 2067/68 (2011): The National Policy on HIV and Sexually Transmitted Infections (STIs).The epidemic in Nepal is predominantly driven by sexual transmission and is characterized as a concentrated HIV epidemic among key populations, including men who have sex with men, male sex workers, transgender individuals, people who inject drugs, female sex workers and their clients, migrants, and prisoners. The national response primarily focuses on accelerating and expanding comprehensive HIV prevention programs, as well as enhancing access to equitable, quality, and gender-sensitive HIV diagnosis, treatment, care, and support services through strengthened health and community systems.

Sexually transmitted infections (STIs) management

Standardizing the quality of STI diagnosis and treatment up to the health post level as part of primary healthcare services has been a key strategy in the national response to HIV. One of the key actions in addressing the concentrated HIV epidemic in Nepal has been the strengthening of documented linkages, including the referral and follow-up mechanisms between BCC services and HIV testing and counseling. This effort also includes enhancing the linkage between HTS and STI services. STI management services targeted at key populations are provided through ART centers.

Overview of the Epidemic

Starting from a 'low level epidemic' over the period of time HIV infection in Nepal evolved itself to become a 'concentrated epidemic' among key populations (KPs), notably with People Who Inject Drugs (PWID), female sex workers (FSW), Men who have Sex with Men (MSM) and Transgender (TG) People in Nepal. A review of the latest epidemiological data, however, indicates that the epidemic transmission of HIV has halted in Nepal. The trend of new infections is evidently taking a descending trajectory, reaching its peak during 2001-2002. The epidemic that peaked in 2000 with almost 8,000 new cases in a calendar year has declined to 942 in 2016 (reduced by 88%). This decline is further accompanied by the decreasing trend of estimated new HIV infections occurring annually in Nepal. Overall the epidemic is largely driven by asexual transmission that accounts for more than 73 % of the total new HIV infections.

National HIV Strategic Plan 2021-2026

The National HIV Strategic Plan (NHSP) 2021-2026, the sixth national strategy with the aim of meeting the global goal of 95-95-95 by July 2026. The commitment by Nepal of both the global "UNAIDS Strategy 2021-2026," and the "Sustainable Development Goals" adopted by the UN General Assembly, include commitments to Fast-Tracking for ending the AIDS

epidemic as a public health threat by 2030. NHSP 2021-2026 vision is to end the AIDS epidemic as a public health threat in Nepal by 2030.

Strategic Directions

Vision: Ending AIDS epidemic in Nepal by 2030

M**ission:** To provide HIV care continuum ensuring inclusive, equitable and accessible services

Goals

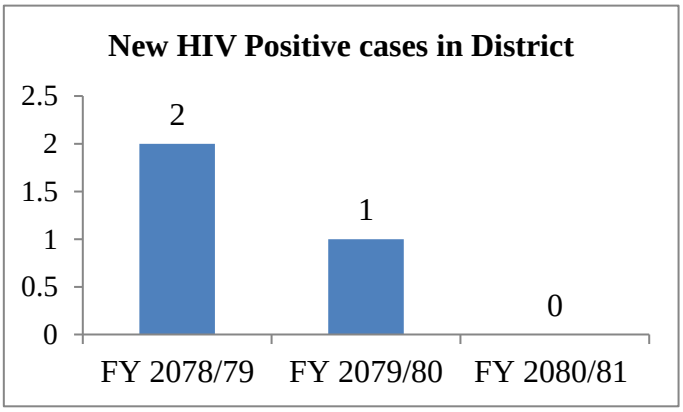
- To prevent new HIV infections,
- To improve HIV related health outcomes of PLHIV
- To reduce HIV related inequalities among PLHIV and KPs.

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 (base line as 2010)
5. Eliminate vertical transmission of HIV
6. Achieve case rate of congenital syphilis of ≤50 per 100 000 live births.

Major HIV Services in district:

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



HIV Status and STI Cases

Indicators	2078/79	2079/80	2080/81
Percentage of Pregnant women who tested for HIV at an ANC checkup	81.6	63.5	85.3
HIV Tested in HTC Program	1737	2792	242
Cumulative HIV Cases	65	67	67
New HIV Cases	1	1	0
Total no. of clients on ART	61	46	48
Total no. of STI Cases	1425	2403	3157

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. Total no. of STI cases in the district are in increasing trends (OPD morbidity data), it mighit be due to increase access of services and improve in recording in HF level.

HIV Positive Clients on ART

Name of LLG	HIV positive Clients on ART in Rolpa Hospital	Clients on ART (Out of Rolpa Hospital)			
		RAHS Ghorahi	LPH Butwal	Bheri Hospital	Teku Hospital
Sunchhahari	4	2	1	0	0
Thawang	0	0	0	0	1
Paribartan	0	0	0	0	0
Gangadev	4	0	0	0	0
Madi	5	2	0	0	0
Triveni	0	0	0	0	0
Rolpa mun.	8	1	5	0	0
Runtigadhi	0	2	0	0	0
Sunilsmriti	16	0	1	0	0
Lungree	11	0	1	0	0
Total	**48**	**7**	**8**	**0**	**1**

Major Activities done in FY 2080/81

- 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 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 base HIV/TB screening and testing for migrant worker and their spouses
- Conduct the PMTCT training to the health workers.

Issues/Challenges, Recommendatios and Responsibilities:

Issues/Challenges	Action to be taken	Responsibilities
Poor supply of STI and Opportunity Infections (OIs) medicines	Consistent supply of STI and OIs medicines	NCASC, PHLMC
Fewer number of HTC sites	All PHC need to be listed as HTC site to increase the test numbers	NCASC
Poor HIV/STI services recording and reporting in hospital setting especially in 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 kit	Should be supply Adequate quantity of HIV test kit	NCASC, PHLMC
PMTCT site could not expand in all BHSC due to untrained human resource.	Should conduct PMTCT training to untrained Health worker	NCASC, HTC

3.5: COVID-19 AND OTHER OUTBREAK PRONE DISEASES

3.5.1: COVID-19

Coronavirus disease (COVID-19) is the infectious disease caused by the coronavirus, SARS-CoV-2, which is a respiratory pathogen. WHO first learned of this new virus from cases in Wuhan, People's Republic of China on 31 December 2019. The outbreak was declared a Public Health Emergency of International Concern in January 2020, and a pandemic in March 2020. Currently Covid-19 is not taken so serious issues, PCR test are not focused as before and the condition becomes a new normal.

Major activities performed in 2080/81:

- Orientation and awareness campaign for prevention, control specially among schools and community
- Series of meeting of stakeholders specially COVID-19 monitoring and coordination committee, local level stakeholders for planning of Vaccination Campaigns
- Vaccination campaign against covid-19
- IEC/BCC Interventions campaign, FM and media broadcasting regularly
- Recording and Reporting

3.5.2: DENGUE

Dengue is a vector-borne disease that is transmitted to humans through the bites of infected mosquitoes (Aedes aegypti and Aedes albopictus). WHO (2009) classified dengue as i) Dengue without warning signs, ii) Dengue with warning signs, and ii) Severe Dengue.

The first reported case of a dengue in the country was in 2005, in a foreigner, in Chitwan but currently it becomes a major disease of concern in Nepal due to widespread infection detected throughout the year, with cases being reported from all 77 districts in the country and the most recent outbreak in 2022 was particularly severe, with 54,784 reported cases and 88 deaths attributed to the disease-more than three times the number of cases in the previous largest outbreak in 2019.

Test and Results (Rolpa):

Indicators	Fiscal Year		
	2078/79	2079/80	2080/81
Total Dengue Tested	3	99	385
Dengue Fever Cases	0	5	22
Incidence of Dengue cases per 10,000 population	0	0.21	0.95

The number of Dengue test in FY 2080/81 is very high as compared to previous fiscal year and the number of Dengue fever cases are also detected which were 5 in previous fiscal year. However, the number of test is very low on the basis of target population.

Major activities in FY 2080/81

- 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

3.5.2: SCRUB TYPHUS

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 to make clinical diagnosis of scrub typhus. There is no human-to-human transmission of scrub typhus. This disease is one of the Neglected Tropical Disease (NTD) 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 were died. Nepal again suffered from scrub typhus outbreak in 2016 with more than 800 reported cases and 14 deaths. Now total of 47 districts were affected by the epidemic.

Test and Results (Rolpa):

Indicators	Fiscal Year		
	2078/79	2079/80	2080/81
Total Scrub Typhus Tested	2	110	297
Scrub Typhus cases reported cases	0	8	52
Incidence of Scrub Typhus cases per 10,000 population	0	0.33	0.95

The number of test in FY 2080/81 is very high as compared to previous fiscal year and the number of Scrub typhus cases are detected which were 8 in previous fiscal year. However, the number of test is very low on the basis of target population.

Major activities in FY 2080/81

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

Issues/Challenges, Recommendations and Responsibilities:

Issues/Challenges	Recommendations	Responsibilities
Lack of guidelines for upcoming vaccination against covid-19	Preparation and dissemination of updated guidelines	FWD/DoHS
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 and other NTDs from OPD	Orientation and review meeting for medical officers and clinicians regarding NTDs	EDCD/MOH
Lack of proper recording of outbreak potential diseases	Proper recording on HMIS and Report via DHIS-2	HFs, LLG

3.6: NON-COMMUNICABLE DISEASE AND MENTAL HEALTH

3.6.1 Non-Communicable Disease (NCDs)

Burden of disease estimates show that burden of NCDs has been steadily rising in Nepal. The premature mortality due to NCDs has risen from 51% in 2066/67 (2010) to 71% in 2075/76 (2019). The proportional mortality of NCDs is ever increasing. Cardiovascular disease (CVDs) is responsible for 30% deaths, cancer 9%, diabetes 4%, chronic respiratory diseases 10% and other NCDs 13%. Increasing life expectancy, demographic and epidemiological transition, rampant urbanization and change in the lifestyle all account to this rising burden of NCDs. The increasing disease burden is associated with decreasing quality of life, increase in DALYs and catastrophic health expenditures. A four-year analysis of National Health Accounts (NHA) reported highest healthcare spending was on NCDs at NPR 37.73 billion. Out of Pocket (OOP) expenditure by disease and health conditions was highest for NCDs with 31% of OOP expenses (NHA, 2068/69-2071/72). Notably, on comparing the STEPS survey from 2066/67 (2008) to 2076/77 (2019), there is increase the prevalence of insufficient physical activity and ncreased body mass index (BMI) in adult population of the country.

Key strategies for the prevention and control of NCDs include:

- Reducing exposure to risk factors through health promotion and primary prevention,
- Early diagnosis and management of people with NCDs,
- Surveillance to monitor trends in risk factors and diseases.

MOHP has already developed and implemented the NCD- Multi-Sectoral Action Plan (2014-2020) followed by Multisectoral action Plan for NCDs (2021-2025) endorsed by the cabinet of ministry

Strategic Approach for MSAP II (2021-2025)

Vision: All people of Nepal enjoy the highest attainable status of health, well-being and quality of life at all age, free of preventable NCDs and associated risk factors, avoidable disability and premature death.

Goal: Reduce the burden of NCDs in Nepal through "whole of government" and "whole of society" approach

Specific Objectives

To raise priority accorded to the prevention and control of non-communicable diseases in the national agenda, policies and programs.

- To strengthen national capacity and governance to lead multisectoral action and partnership across sectors for the prevention and control of NCDs
- To reduce risk factors of NCDs and address underlying social determinants across sectors.
- To strengthen health systems through provision of people-centric, comprehensive, integrated, and equitable care for improved prevention and control of NCDs.
- To establish NCD surveillance, monitoring and evaluation system for evidence-based policies and programs

Targets: The overarching target is to reduce premature death from major NCDs by 25% by 2025 and by one third by 2030

Nepal Package of Essential Non Communicable Disease (PEN) program

The Package of Essential NCDs (PEN) and HEARTS toolkit enhances fairness and effectiveness in primary healthcare for limited-resource settings, identifying essential technologies, medications, and risk prediction tools. It outlines protocols for implementing key interventions for NCDs and establishes a technical and operational framework for integrating these interventions into primary care, evaluating their impact. WHO PEN, a cost-effective package for low-resource settings, strengthens health systems by offering prioritized interventions, optimizing limited resources, and empowering primary care through user-friendly tools. PEN program has been scaled in all seven provinces across 77 districts of Nepal.

The objectives of PEN program are:

- To strengthen health systems to address the prevention and control of NCDs and underlying social determinants through people centered primary health care.
- To strengthen national and local capacity and partnership to accelerate country response for the prevention and control of NCDs
- To reduce modifiable risk factors for non-communicable diseases and underlying social determinants through creation of health-promoting environments.

Status in Rolpa FY 2080/81 (New Cases

S.N.	NCDs Burden/Condition	No. of cases diagnosed or treated
1	Hypertension	1738
2	CVD	11
3	Diabetes Mallitus	763
4	COPD	923
5	Asthma	496

S.N.	NCDs Burden/Condition	No. of cases diagnosed or treated
6	Cancer	0
7	Alcohol Liver Disease	128
8	RTI	405
9	Fall	2145
10	Bites	389
11	Burn	412
12	Drowning	6
13	Self Harm	69
14	Violence	80

स्थानीय तह मार्फत जीविकोपार्जन भत्ता रु. ५००० प्राप्त सेवाग्राहीहरुको विवरण संख्या (आ.व. २०८०/८१)

Name of LLG	Disease/Condition			Total
	Spinal Paralysis	Kidney Disease	Cancer	
Sunchhachari RM	0	3	3	6
Thabang RM	1	2	4	7
Paribartan RM	2	1	14	17
Gangadev RM	1	3	5	9
Madi RM	1	2	8	11
Tribeni RM	2	9	9	20
Rolpa RM	0	13	12	25
Runtigadhi RM	0	13	12	25
Sunilsmriti RM	3	4	20	27
Lungri RM	0	1	3	4
Total	**10**	**51**	**90**	**151**

Source: Data received vertically from LLG

दुई लाख रुपैया उपचार सहगोगकालागि संघिय सरकारलाई स्थानीय तहबाट सिफारिस गरिएको विवरण (आ.व. २०८०/८१)

Name of LLG	Disease/Condition			Total
	Kidney Transplant	Cancer	Valve Transplant	
Sunchhachari RM	0	8	0	8
Thabang RM	2	2	0	4
Paribartan RM	0	5	0	5
Gangadev RM	1	2	1	4
Madi RM	0	2	1	3
Tribeni RM	6	10	1	17
Rolpa Mun	1	13	0	14
Runtigadhi RM	1	3	1	5
Sunilsmriti RM	0	20	5	25
Lungri RM	1	2	0	3
Total	**12**	**67**	**9**	**88**

आ. व. २०८०/८१ मा बिपन्न नागरिक उपचार कोषबाट उपचार सेवा प्राप्तिकालागि स्थानीय तहबाट सिफारिस गरिएका ८ प्रकारको कडा रोगहरुको विवरण संख्या

(Impoverished Patients Provided with Treatment Support for Serious Diseases)

Name of LLG	Kidney Disease	Heart disease	Cancer	Parkinsons	Alzimers	Spinal Injury	Head Injury	Sickel Cell	Total
Sunchhachari	4	0	10	0	0	0	0	0	14
Thabang	0	1	4	0	0	3	1	0	9
Paribartan	3	2	8	0	0	2	0	0	15
Gangadev	8	5	4	0	0	2	0	0	19
Madi	3	4	7	0	0	2	0	0	16
Tribeni	6	9	10	0	0	1	0	0	26
Rolpa	3	6	15	0	0	1	0	0	25
Runtigadhi	4	2	7	0	0	0	0	0	13
Sunilsmriti	6	15	20	0	1	3	2	0	47
Lungri	1	4	4	0	0	0	0	0	9
Total	**38**	**48**	**89**	**0**	**1**	**14**	**3**	**0**	**193**
Source: Data received vertically from LLG									

3.6.2 Mental Health

History of mental health services in Nepal roots back to2018 (1961) as an out-patient service from Bir Hospital. Mental health problems constitute of 18% of the total NCDs and is the fourth leading cause of disability. National Mental Health Survey 2077 (2020) showed that 10% of the adult population had some mental disorder in their lifetime and 4.3% currently had some mental disorder. The prevalence of suicidality was 7.2%, current suicidality was 6.5%, lifetime suicidal attempts were 1.1% and risk of future suicidal attempts was 0.3%. There is increased risk among the vulnerable like- poor, hard to reach population, homeless, conflict affected, survivors of violence, minority groups, non-binary gender, prisoners, people in humanitarian setting are more prone to mental health problems. In addition to these, mental disorders are stigmatized in the society and the people are reportedly named crazy and taken as a matter of embarrassment for a holistic approach to road safety, emphasizing improvements in road and vehicle design, law enforcement, and timely emergency care. It also supports policies promoting walking, cycling, and public transport for their health and environmental benefits.7 Recognizing these challenges, the GoN has progressively increased its commitment to mental health, resulting in the establishment of a Non- Communicable Diseases and Mental Health (NCDs and MH) Section. Mental health care is now a fundamental service according to the Public Health Services Act, 2075, and is included in the BHS and emergency health services as defined by Public Health Service Resulation. The National Health Policy of 2076, in section 6.17.5, outlines a strategy to expand and integrate mental health services into the broader health system. Remarkably, Nepal has endorsed its National Mental Health Strategy and Action Plan (NMHSAP) 2077 as an umbrella strategy to guide the overall mental health program planning and service delivery.

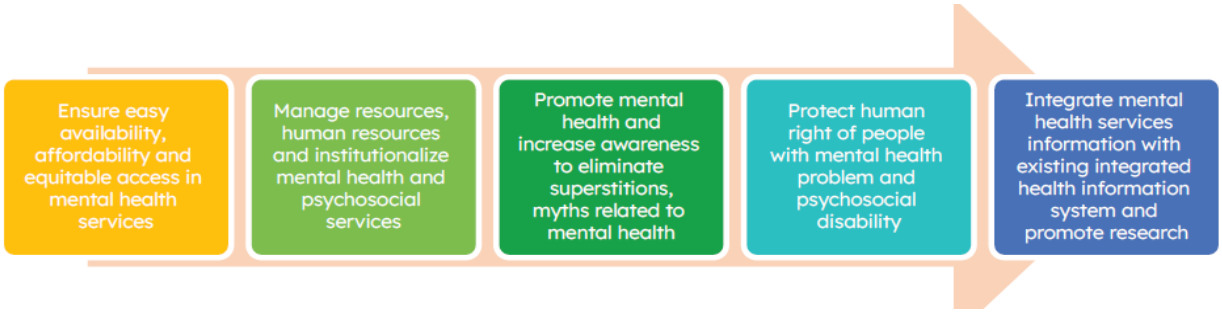


Figure: Five strategies of National Mental Health Strategy and Action Plan 2077

Mental Health Policy 2019 and Mental Health Plan 2020

Based on National Health Policy 2019, section 6.17.5 National Mental Health Strategy and Action Plan (2020) was formulated by government which provides a more comprehensive description of Country's plans for mental health care. This strategic Action Plan describes the provision of free primary care mental health services for all parts of the country.

Following are the key components incorporated within the National Mental Health Strategy and Action Plan 2020.

- Integration of mental health at Primary Health Care level,
- Strengthening mental health at Secondary Health care level,
- Service user engagement in policy development and planning barriers to participation in policymaking activities

Status in Rolpa FY 2080/81

S.N.	Mental health Burden/condition	No. of new cases diagnosed
1	Alcochol Use Disorder	40
2	Anxiety	122
3	Conversion Disorder	54
4	Depression	40
5	Psychosis	8
6	Epilepsy	12
7	Suicide Attempt	8

Issues/Challenges, Recommendations and Responsibilities

Issues/Challenges	Recommendations	Responsibilities
Poor recording and reporting	Priority for recording and reporting related to NCDs and Mental Health	HFs, LLG
Lack of training regarding NCD PEN and Mental health towards service providers and counsellor	Provision training towards paramedics and nurses regarding the NCD	NHTC/HTC/MOH/ HD

3.7. DRINKING WATER QUALITY SURVEILLANCE

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 diarrhoea, 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, envisages surveillance of drinking water quality at central, provincial and local level through the Ministry of Health and Population and underlying institutions. EDCD, being secretariat of the National Drinking Water Quality Surveillance Committee, drinking water quality surveillance related activities are conducted through this section at central level.

At District level, drinking water quality surveillance is performed by HO to ensure the quality of drinking water and advocacy for the improvements. In FY 2080/81 HO Rolpa was performed different activities like stakeholder meetings, water quality test and sharing the results through local medias etc. Water quality test performed at 198 different locations representing all local levels. Got the result that 52% of water had e.coli which is the major organisam for water contamination. HO Rolpa has planned to advocate and build commitment via district disaster management committee meeting and facilitate to formation of local level water quality surveillance committee, formation and implementation of water safely plan and to make water quality surveillance effective and sustainable throughout district.

Result of water quality test (FY 2080/81)

Local Level Name	Total tested sample	Test Results (e. coli)		Percentage of e.coli positive
		Positive	Negative	
Sunchhahari RM	20	8	12	40
Thabang RM	20	8	12	40
Paribartan RM	20	12	8	60
Gangadev RM	20	10	10	50
Madi RM	20	12	8	60
Tribeni RM	20	11	9	55

Rolpa Mun	18	10	8	55.5
Runtigadhi RM	20	9	11	45
Sunil Smriti RM	20	11	9	55
Lungri RM	20	11	9	55
Total	**198**	**102**	**96**	**52**

Laboratory details in Rolpa district

S.N.	Local Level Name	Laboratory Locations	No. of Lab Sites
1	Sunchhahari RM	Powang HP	1
2	Thabang RM	Thabang HP	1
3	Paribartan RM	Rangsi HP/Kureli HP/ CHU Baghmara	3
4	Gangadev RM	Jinawang HP	1
5	Madi RM	Ghartigaun HP/Bhawang HP/Talabang HP/Korchawang HP	4
6	Tribeni RM	Nerpa HP/Nuwagun HP/Gairigaun HP	3
7	Rolpa Mun	Rolpa Hospital/Kotgaun HP	2
8	Runtigadhi RM	Holeri PHC / Mashina HP	2
9	Sunil Smriti RM	Sulichour PHC/ Ghodagaun HP/Khungri HP/Gajul HP/	4
10	Lungri RM	Wadachour HP	1
Total			**22**

CHAPTER 4

CURATIVE SERVICES

Government of Nepal is committed to improving the health status of rural and urban people by delivering high-quality health services throughout the country. The policy is aimed at providing prompt diagnosis and treatment, and referral of cases through the health network from community health facilities (PHCC/HP) to the specialized and central public hospitals. Curative Service is one of the important components of Health Care Delivery System in Nepal. Health Care Delivery Network is committed to provide Quality Service to improve the Health Status of people on Equity basis. The Policy regarding Curative Service in district is aimed at providing appropriate Diagnosis, Treatment and Referral Service throughout the Health Network from the PHC-Outreach Clinic to the District Hospital.

The overall objective of curative services are to reduce morbidity, mortality by ensuring the early diagnosis of diseases and providing appropriate and prompt treatment. In Rolpa district, curative service is provided through the PHCs, HPs and Provincial Level Hospital. Besides these, preventive as well as few curative services provided through Out-reach Clinics, BHSC, CHU and UHC through out the district. The private health institutions are also the part of service providers in the district especially in outpatient services. However, case load in Rolpa Hospital and two PHC is very high.

Minimum Service Standards (MSS) of Hospitals and Health Facilities

MSS stands out as a highly successful tool for evaluating the service readiness and service availability of health institutions. Using a standardized set of assessment standards, MSS gives a percentage score that indicates the status of institutions' readiness and service availability. Initially launched in 2072 as the Hospital Management Strengthening Program, MSS initially focused on assessing the then district level hospitals.

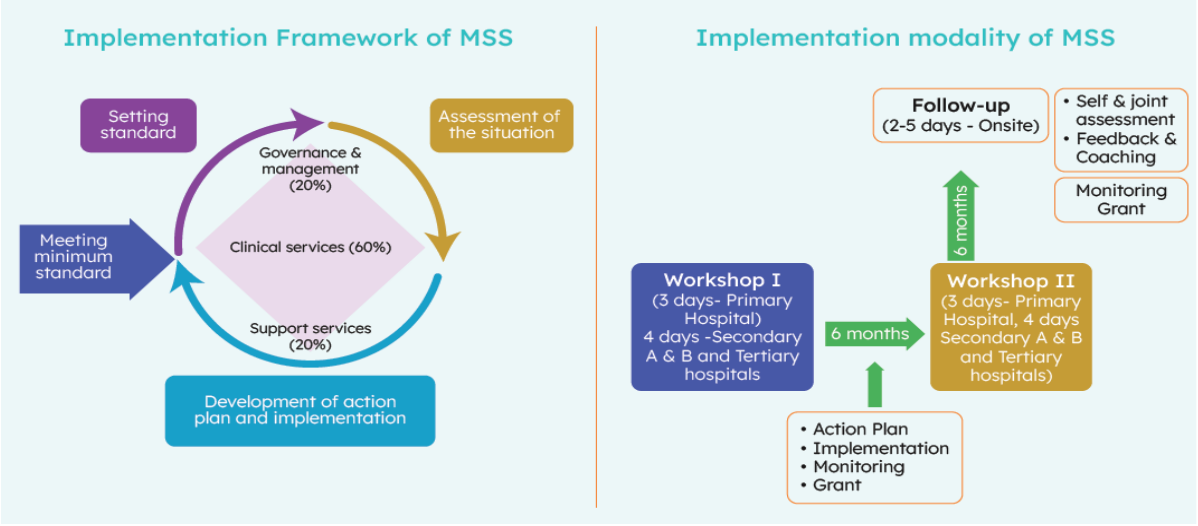


Figure : Key concepts, implementation framework and implementation modality of MSS

Curative service strategies

- To make curative health services available in an integrated way in rural areas through healthposts and PHCCs.
- To establish hospitals based on population density and patient load with at least one hospital per local level.
- To establish referral hospitals in district and province to provide specialized services related to paediatrics, gynaecology, general surgery, general medicine, eye care, dermatology, orthopaedics and psychiatry etc.
- To equip central hospitals with sophisticated diagnostic and other facilities to provide specialised and super-specialty services. Specialist curative care services will be extended to remote areas, as and when required, through mobile teams.
- To extend referral systems to provide rural people with access to services from modern well-equipped hospitals.
- To strengthen diagnostic services such as laboratories and X-ray services at hospitals.
- To extend service provision through more outreach clinics and by considering the relocation of existing facilities
- To provide basic curative services free in up to 25 bed hospitals.
- To promote private medical colleges, hospitals, nursing homes and hospitals run by INGOs,
- NGOs and private practitioners to complement public health care provision.
- Maternal and Neonatal health service such as ANC, PNC, Safe delivery and Safe abortion.

Rolpa Hospital

Rolpa Hospital is Located in Rolpa Municipality Ward no 2, Reugha of Rolpa district. It is around 4.5 km away from Liwang, district headquarter of Rolpa. It was established in as a Health Post in 2021 BS and was upgraded to Health Centre in 2045 BS. Hospital was upgraded to District Hospital in 2061 BS. The name of hospital was changed to **Rolpa Hospital,** Reugha in 2075. Hospital was upgraded to 50 Beded (Secondary A) by Provincal Government.

It has covered an area of 75 ropani. It is also taken as only one referral center of Rolpa District. It is the main responsible institution at Rolpa to provide curative health services to the people to Rolpa and some areas of East Rukum.

Hospital Bed

Description	Total No
Sanctioned Beds (Government)	50
Total Operational Beds	47
Total Surgery Beds	7
Total Pediatric Beds	6
Maternity Beds	12
Post Operative	3
SNCU	4

Medicine	7
Emergency Beds	7
Geriatric	2
Isolation Beds	2
OCMC	2

Major Hospital Services:

Preventive Service	Promotive Services	Curative Services	Others Services
• Immunization Services • Family Planning Services • Safe Abortion Services • Safe Motherhood • PMTCT Services • HTC Service • ART Service etc.	Health Education & Counseling	• Out Patient Services • In Patient Service • Emergency Services • Safe motherhood services • Obstetric Care • CEONC & Other Surgeries • DOTS Service, • Diagnostic Services (Lab, X-ray, USG, ECG etc) • Physiotherapy Services • Dental Services • Pharmacy • Ophthalmology Services etc	• OCMC Services (GBV Support • Counselling • Curative Service • Referral Service) • Health Insurance • Medicolegal Services • Ambulance Services • Biomedical Maintenance etc.

Major Hospital Indicator Fact-Sheet (Three Years Trends)

Indicators	2078/79	2079/80	2080/81
HOSPITAL PERFORMANCE INDICATORS			
Reporting Status (%)	100	100	100
Bed Occupancy rate	37	22	42
Number of maternity beds	11	11	12
Average length of Stay (Days)	3	4	3
Throughput	48	46	52
Bed Turnover Interval	7	8	7
Surgery related death rate	0	0	0
Average number of radiographic image per day	18	16	18
Average number of laboratory tests per day	178	344	448
Average number of USG per day	15	16	17
Average number of ECG per day	3	3	5
Infection rate among surgical cases	0	0.58	0.68
Total surgery Cases (major + minor)	55+217	127+289	135+300
% of Major Surgery among total surgery cases	20.2	36.44	31.03
Doctor: In-Patient ratio	1:142	1:320	1:251
Doctor: Out-Patient ratio	1:4487	1:7555	1:5725
Nurse: In-Patient ratio	1:64	1:71	1:97

Death within 48 hrs. of admission	2	5	3
Death after 48 hrs. of admission	0	1	3
Proportion of In-Patient among total patient	5.3%	4.23%	4.3%
OUT-PATIENTS INDICATORS			
Number of Out Patients	23976	30218	40077
Proportion of Out Patients among total patients	79.6	79.6	88.7
Out Patients Sex Ratio	0.65	0.60	0.63
MATERNITY SERVICES			
Total No of Normal Delivery	271	390	366
Total No of C/S	55	118	75
Total No of Abortion (CAC)	218	226	169
Total No of Abortion (PAC)	86	76	72
Proportion of <20 yrs women receiving comprehensive abortion care	0.1	0.09	0.08
Proportion of long term contraceptive among post abortion contraception used	6%	11%	15%

Top 10 Morbidities in OPD Visit (FY 2080/81)

Causes of Morbidity	% among total OPD visits	Rank
Gastritis (APD)	4.50%	1
Fever	4.06%	2
URTI	3.13%	3
Dental caries	3.12%	4
Headache	2.74%	5
Cough	1.86%	6
LRTI	1.74%	7
Fatigue and weakness	1.61%	8
General Consideration on pain	1.52%	9
UTI	1.36%	10
Total OPD visit	**40077**	

Top 10 Morbidities in IPD Visit in FY 2080/81

Rank	Causes of Morbidity	% Among total IPD Visits
1	COPD	5.45%
2	Acute Abdomen	3.40%
3.	URTI	2.72%
4.	LRTI	2.38%
5.	Pneumonia	2.27%
6.	AGE	2.15%
7.	UTI	1.98%
8.	Fever Under Evaluation	1.93%
9.	Tonsillitis	1.53%
10	Appendicitis	1.47%
Total IPD		**N=1761**

Age and Sex wise Registered OPD Patient (FY 2080/81)

Age Group	New Client Served			Total Client Served		
	Female	Male	Total	Female	Male	Total
0-9 Years	2273	3315	5588	2506	3551	6057
10-14 Years	752	1000	1752	843	1109	1952
15-19 Years	1493	975	2468	1653	1074	8009
20-59 Years	14769	6682	21451	16106	7252	23358
60-69 Year	1571	1274	2845	1708	1374	3082
70 and Above	1505	1157	2662	1627	1274	26440
Total	**22363**	**14403**	**36766**	**24443**	**15634**	**40077**

Emergency services by Sex and Age group in FY 2080/81

Age Group	Female	Male	Total
0-9 years	460	546	1006
10-14years	262	233	495
15-19 years	312	260	572
20-59 years	1320	1039	2359
60-69 years	199	157	356
>70 years	171	116	287
Total	**2724**	**2351**	**5057**

Average number of Diagnostic test per day

Particular	2078/79	2079/80	2080/81
Average number of Lab Test per day	178	344	448
Average no of Radiographic Image per day	18	16	18
Average no of ECG per day	3	3	5
Average no of USG per day	15	16	17

Zoonotic Disease Control

Indicators	2080/81	Remarks
Total Number of Case of Animal Bite	148	
Total Number of Case Treated with Antirabies Vaccine	148	
Total Number of Cases of Snake Bite (Poi+Non Poi)	24	
Total number of Case Treated with ASV	24	

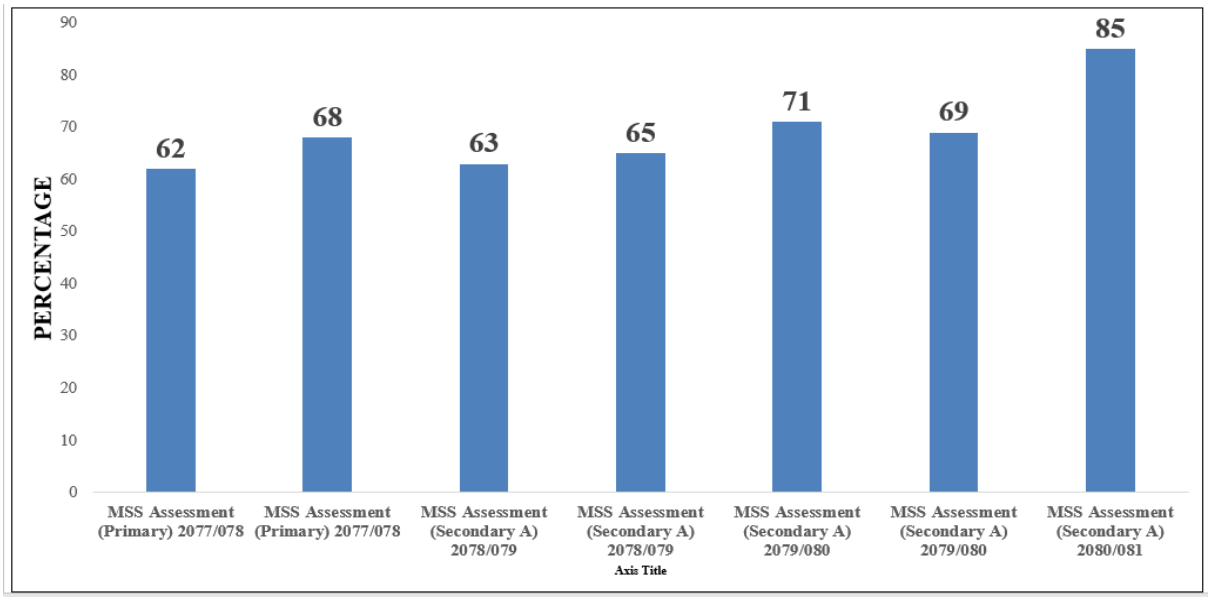
Different Lab Investigation done in last three Fiscal Year

FYs	Bacterology	Biochemitry	Virology	Parasitology	Immunology	Hematology	Hormonal/ Endocrine	Total
2078/79	315	16747	5169	6439	8066	34166	2397	73299
2079/80	460	38558	8590	7681	9757	58606	4377	128029
2080/81	122	54060	6757	7539	23558	80518	6796	179350

Beneficiaries of Social Service unit in FY 2080/81

S.N.	Type of beneficiaries	Total Number		
		Female	Male	Total
1.	Poor and Ultra Poor	15	12	27
2.	Person with disability	4	2	6
3.	Senior citizens	643	475	1118
4.	Victims of Gender-Based Violence	53	0	53
5.	FCHV	6	0	6
Total		**721**	**489**	**1210**

Minimum Service Standards: MSS Score Trend (2077/78-2080/81)



Asthma and Bronchitis Programme

"Asthma and Bronchitis disease treatment Management" is a program implemented by Lumbini Province. According to this, a Patient with Chronic Respiratory Disease will receive free treatment up to maximum of 50 thousand in Hospital under Lumbini Provincial Government. Disease under this Program includes Asthma, COPD, OLD (Occupational Lung Disease), Pulmonary Hypertension, and providing services among all citizen of Lumbini Province through the entire provincial and district level hospitals under lumbini Province.

Asthma and Bronchitis programme beneficiaries

S.N.	Fiscal years	Number of Patients	Remarks
1	2078/79	23	
2	2079/80	37	
3	2080/81	35	

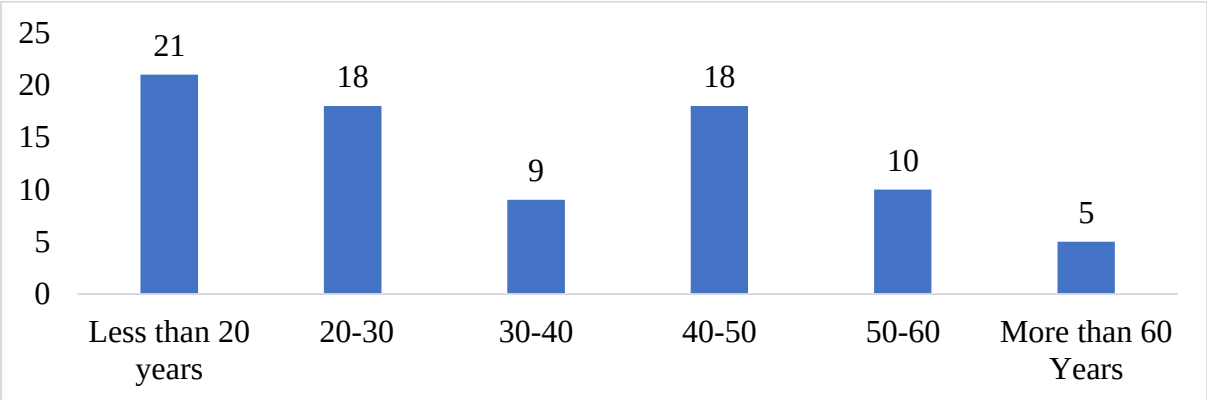
Types of Medico-legal Case in FY 2080/81

Particulars	Number of Cases
Autopsy	81
Injury Examination	12
Gender Based Violence Examination	53
Others	274
Total Cases	**420**

Cause of Death (According to Autopsy Done in Hospital)

Particulars	Total numbers		
	Female	Male	Total
Hanging	6	21	27
Poisoning	8	2	10
RTA	7	12	19
Drowning	2	4	6
Fall Related Trauma	4	4	8
Assault Related Trauma	0	1	1
Natural Calamities (Landslides, Lightening)	2	0	2
Burn Related	1	0	1
Others	2	5	7
Total Deaths	32	49	81

Trends of Suicide in Age wise (Autopsy done in Rolpa Hospital in numbers)



आ.व. २०८०/०८१ मा रोल्पा अस्पतालबाट गरिएको मुख्य/मुख्य कृयाकलापहरु

- सम्माननीय प्रधानमन्त्रीज्यूबाट नवनिर्मित भवनको समुद्घाटन गरी नयाँ भवनबाट सेवा सञ्चालन गरिएको। साथै सो कार्यक्रममा स्त्री तथा प्रसुतिरोग सम्वन्धी निशुल्क विशेषज्ञ स्वास्थ्य शिविर सन्चालन गरिएको।
- अस्पतालमा BNMT द्धारा शुद्ध खानेपानीको लागी UV Water Purification Plant जडान गरिएको।
- अस्पतालका बेडहरुमा Oxygen तथा Suction Pipeline जडान गरी सेवा सुचारु गरिएको।
- सिकिस्त विरामीहरुलाई रिफर गरिएको अस्पतालमा स्वास्थ्यकर्मीको साथमा लैजाने ब्यवस्था गरिएको।
- स्त्री तथा प्रसुतिरोग विशेषज्ञ र बालरोग विशेषज्ञद्धारा नियमित सेवा सुरुवात गरिएको।
- SNCU सेवाका लागी आवश्यक औजार उपकरण सहितको सेवा सुरुवात गरिएको।

- राष्ट्रपति महिला उत्थान इकाई, महिला वालबालिका तथा जेष्ठ नागरिक मन्त्रालय सिँहदरबार काठमान्डौको सहयोगमा अत्याधिक रक्तश्राव भई जटिलता सृजना भएको महिलालाई हवाई उद्दार गरिएको।
- महिलाहरुमा पाठेघर खस्ने समस्याको निशुल्क शल्यक्रिया शिविर सन्चालन गरिएको र सो शिवरमा १३७ जनाको सफल शल्यक्रिया गरिएको।
- प्रयोगशाला विभागमा अत्याधुनिक मेसिन जडानगरी Anti -TPO, ADA, LDH, Vitamin B12 र Vitamin D को जाँच थप गरि सेवा सन्चालन गरिएको।
- हाडजोर्नि तथा नशा रोग विशेषज्ञ प्रा. डा. गोविन्द के.सी.द्धारा ४ दिने निशुल्क OPD सेवा सन्चालन गरिएको।
- अस्पतालमा आएका विरामीहरुको मृत्यु भएमा Death Audit को कार्य सुरु गरिएको।
- अस्पतालका Department हरुमा Department wise र Inter-Department बैठक बसेर समस्याहरुको समाधान गर्ने गरिएको।
- फोहोरमैला ब्यावस्थापनका लागि भौतिक पूर्वाधारको निर्माण कार्य सुरु गरिएको।
- सुशील कोइराला स्मृति प्रतिष्ठान रोल्पाको आयोजना, रोल्पा अस्पताल रेउघाको सहआयोजना र काठमाण्डौ मेडिकल कलेजको प्राविधिक सहयोगमा बृहत निःशुल्क स्वास्थ्य शिविर सन्चालन गरिएको र सो शिविरमा २१५४ जनाले सेवा लिएको जसमध्ये २६० जनालाई शिविरबाट निःशुल्क शल्यक्रियाका लागि प्रेषण गरिएको।

CHAPTER 5

SUPPORTING PROGRAM

5.1. FEMALE COMMUNITY HEALTH VOLUNTEER PROGRAM

In the year 2045/46 (1988), GoN initiated the FCHV Programme across 27 districts, eventually expanding its reach to encompass all 77 districts. Initially, a single FCHV was appointed per ward, with a subsequent shift to a population-based approach introduced in 28 districts in 2050 B.S. The goal of the program was to improve the health of local community peoples by promoting public health. This includes imparting knowledge and skills for empowering women, increasing awareness on health related issues and involving local institutions in promoting health care.

FCHVs are selected by health mothers' groups. FCHVs were provided with 18 days (9 +9 days) in fiscal year 2078/79. Ten days basic training package has been developed and rolled out and 4 days' refresher training in every 4 years. After the training, they receive medicine kit boxes, manuals, flipcharts, ward registers, IEC materials, an FCHV bag, signboard and identity card. Family planning devices (pills and condoms only), iron tablets, vitamin A capsules, Deworming tablet and ORS are supplied to them through health facilities.

The major role of FCHVs is to advocate healthy behaviour among mothers and community people to promote safe motherhood, child health, family planning and other community based health issues and service delivery. FCHV distributes condoms and pills, ORS packets and vitamin A capsules, treat pneumonia cases, refer serious cases to health institutions and motivate and educate local people on healthy behaviour related activities. They also distribute iron tablets to pregnant women.

FCHVs' role had been highly acknowledged by Nepal Government in achieving milestones of Millennium Development Goal 4 and 5 and expected the same in the era of Sustainable Development Goal by 2030 through contextual modification. Nepal government is committed to increase the morale and participation of FCHV for community health. Policies, strategies and guidelines have been developed and updated accordingly to strengthen the programme. The first FCHV programme strategy was developed in 2047 (1990) and was continually revised. In 2067 (2010), FCHV Programme strategy was rewritten to promote strengthened national programmes which underwent the first or the latest amendment in 2076. This amended strategy highlights the context specific revision like change in FCHV selection criteria, institutional arrangement to support FCHV program.

The government is committed to increase the morale and participation of FCHV for community health. Policies, strategies and guidelines have been developed and updated accordingly to strengthen the programme. The FCHV programme strategy was revised in 2067 (2010) to promote a strengthened national programme. In fiscal year 2064/65 the Ministry of Health and Population established FCHV funds of NPR 50,000 in each VDC mainly to promote income generation activities. FCHV are recognized for having played a

major role in reducing maternal and child mortality and general fertility through community-based health programmes.

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

Objectives

- Mobilize a pool of motivated volunteers to connect health programmes 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 of health care services among community people.

Facilities for FCHV:

- A total of NPR. 10,000/- is provided to each FCHV as dress allowance every year.
- A travel allowance is provided to each FCHV as transportation cost during participation in program and campaign.
- Since 2071/72 the government has allocated 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. Addition with this, Lumbini Province Government started to felicitation by Rs 50,000 at the time of retirements, over 60 years of age.
- International World Volunteer Day (5th December) is celebrated as Female Volunteer day every year.
- Government of Nepal bears the 50% of premium of health insurance for individual FCHV and they are one of the target groups to receive service through Social Service Unit of Health Facilities.

Major Indicators of FCHV Program

Indicators	**Fiscal Year**		
	2078/79	**2079/80**	**2080/81**
No. of FCHVs	459	459	459
% of FCHVs Reporting	100	100	100
Health Mother's group meeting held (%)	96.8	97.6	99.1
Average no. of people served by FCHV per month	23.7	26.3	26.2

The table shows that, mother's group meeting held has been increase as compare to FY 2079/80 i.e. 97.6% to 99.1%. Likewise, health mother group meeting held by FCHV was increasing trends in three FYs.

Major Activities carried out during the FY 2080/81

- Biannual review meeting of FCHV programme
- FCHV day celebrated on 5th December with FCHV felicitation program for best performer FCHVs
- Basic and Refresher training for FCHVs
- Distribution of dress allowance for FCHVs RS 10000 per FCHV
- Farewell Programme for ageing and low educational FCHVs; and replaced by educated FCHV
- 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 programmes including mobile health program

Issues/Challenges, Recommendations and Responsibilities

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

5.2: HEALTH TRAINING PROGRAM

The National Health Training Centre (NHTC) is the apex body for developing human resources for health in Nepal. NHTC was established in 2050 BS to coordinate andmanage all trainings under MoHP. It caters to training needs of all human resources under departments and divisions of DoHS and MoHP. The key guiding document for NHTC is National Health Training Strategy 2060/61 (2004). Additionally, it is guided by the vision of theNational Health Policy and health sector strategic plans.

Training is the 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 for effective health services delivery in the country with its optimal level quality of training. Training is an important tool for human resource for skill development. District level training Programs are conducted based on program perspective as set by 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 2080/81

- Training need assessment
- HMIS training to newly recruited health workers
- eLMIS Rollout Training
- DHIS-2 Training to all health coordinators and health facility level staffs
- Maternal and Neonatal Health (MNH) update training to nursing staffs
- School health and ASRH training to School teacher and HF incharge
- 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 to the nursing staffs and office assistant
- IPC and sanitation orientation to the FCHV
- VCAT training to nurses

5.3: HEALTH EDUCATION, INFORMATION AND COMMUNICATION

The goal of the Health Information, Education and Communication Programme is to promote health, prevention and control of diseases and increase the maximum utilization of available health care services.

National Health Education Information and Communication Center (NHEICC), established in 2050 (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 achieve goals and SDGs.

Objectives

To promote health of the people by raising healthawareness and preventing diseases through the efforts of the people themselves and full utilization of available health services

Strategies:

- Advocacy, social mobilization and behaviour change communication are the major strategies for health promotion, education and communication.

The specific strategies are as follows:

- Implementing a one-door integrated approach for all health communication programmes under MoHP
- Ensuring adequate budget for health communication programmes
- Coordinating with concern stakeholders through technical committees
- Ensuring implementation of health communication programs through health infrastructure at all tiers of federal government, i.e., federal, provincial and local levels in a decentralized manner.
- Mobilizing communication media, methods and materials for the prevention of diseases and promotion of health
- Standardizing health messages and information for uniformity and appropriateness
- Using entertainment approach with an education format for disseminating health messages and information
- Ensuring that all stakeholders disseminate health messages and information after taking consent from concerned MoHP authorities.
- Encouraging the media to disseminate messages and information on health issues
- Encouraging the dissemination of health messages and information through public-private partnerships
- Discouraging negative messages and information that is harmful to health.
- Prioritizing lifestyle diseases prevention messages and information dissemination
- Building the capacity of health workers to plan and implement health communication programmes.
- Ensuring the quality, uniformity and standardization of health messages and materials through technical committees
- Introducing new communication technologies for health promotion and health communication

- Coordinating with academia for building the capacity of health workers on health promotion and health communication
- Strengthening monitoring and supervision activities to determine the gaps in knowledge, attitudes and practices among target audiences and service providers.

Major Activities carried out in FY 2080/81:

- Public awareness program on non-communicable disease at 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 program 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 level 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 elder people and differently able people throughout the district and benefited around 3600 people round the year
- Mobilize all the FM/radio and printed media within district for advocacy and health promotional program

5.4: LOGISTICS MANAGEMENT INFORMATION SYSTEM

To streamline logistics management, LMIS unit was established within the Logistic 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.

Management Division transitioned to an electronic Logistic Management System (eLMIS) from Baishakh 2075 to strengthen supply chain management processes and enhance LMIS data entry and visualization, aiding informed decision-making.

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 2080 (16th July of 2023), there are a total of 32,570 live sites, comprising 2,539 SDPs, 753 LLGs, 77 Health Offices, and provincial and 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 staffs. Additionally, eLMIS ensures the safety of data, providing a secure platform or managing inventory information.

Overall Objective

To plan and carry out the logistics activities for the uninterrupted supply of essential medicines, vaccines, contraceptives, equipment, HMIS/LMIS forms and allied commodities (including repair and maintenance of bio-medical equipment) for the efficient delivery of healthcare services from the health institutions of government of Nepal in the country.

There is a practice of pull system in 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 per quarterly and sometimes immediately if required. HO also demands accordingly to the Provincial Health Logistic Management Center (PHLMC), Center Medical Store or even Logistic Management Section of DOHS. However, pull system has not been fully made out of practice since HO and LLG supplies the regular drugs and commodities without the demand of peripheral health facilities.

eLMIS Reporting Status by Institutions (%)

Type of Health Facilities	2078/79	2079/80	2080/81
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 is cent percent over last three FYs through all health facilities including Hospital. The eLMIS has helped to generate accurate and reliable feedback reports, thereby contributing to improve logistics functions like budgeting, quantifying, forecasting, procurement, storage, transportation and distribution of FP, MCH commodities and essential drugs. eLMIS has played a key role in reducing stock-out rates and increasing year-round availability of key health commodities through close monitoring. Similarly, HO has implemented web-based LMIS (e-LMIS) and Inventory reporting system during FY 2074/75.
Rolpa hospital also implemented e-LMIS during the FY 2076/77. Altogether 103 i.e. 76.29 percentage of sites have performed their supply chain management related task via eLMIS platform in the Rolpa district and all of those are in operational regularly as per guideline**.**

HO, Rolpa have planned to roll out e-LMIS training to additional sites and scaling up throughout the district during FY 2081/82 along with refresher training.

Round the year, no any scarcity and stock out of key commodities within the district and peripheral sites. Near expiry medicine were transferred to nearby high case loaded HF for early consumption which helps to reduce wastage.

Current eLMIS online and LMIS sites in Rolpa District

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
BHC	21	1
Total	**103**	**32**

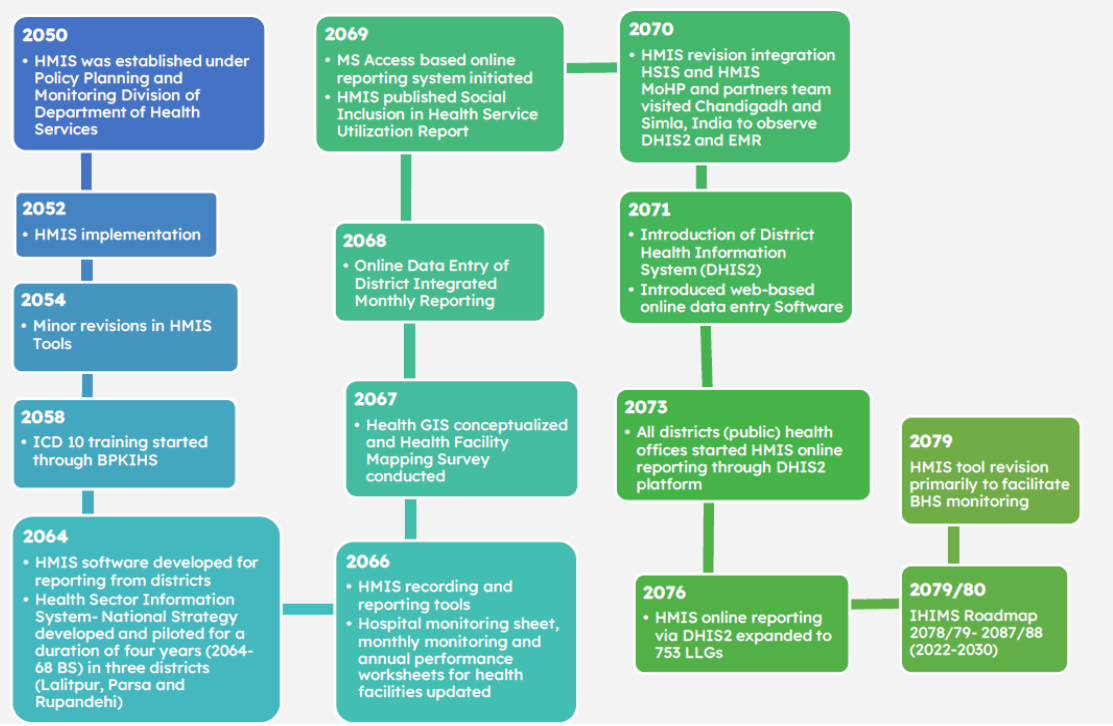
Major Activities carried out in FY 2080/81

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

5.5: HEALTH MANAGEMENT INFORMATION SYSTEM (HMIS)

Health Management Information System (HMIS) operating on DHIS2, an ICT friendly platform with highly scalable features, manages health sector information in an integrated and comprehensive manner through a one door system. To reach its current state, HMIS has come through several significant milestones. Revision of the HMIS tool in FY 2078/79 was the massive effort in 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.

Milestone on HMIS tool development



The major functions of the HMIS are;

- To collect and manage the health service delivery information from all levels of health service delivery outlets including services at the communities by FCHVs and community level health workers
- To verify, process, analyze the collected data and operate data bank
- To provide feedbacks on achievements, coverage, continuity and quality of health services to program divisions/centers, HDs, hospitals and district public/ health offices
- To draw indicators and relevant information and support to the program management
- To disseminate health information through efficient methods and technologies
- To publish a comprehensive Annual Report of Department of Health Services
- To develop competent human resource for Health Information Management System
- To support for conducting National Performance Review of health programs and support to regional, district and below level reviews

- To improve the information management system and modify the tools, techniques and methodologies
- Verify, process and analyze of collected data and operate a databank
- Disseminate health information through efficient methods and technologies.
- Provide HMIS and DHIS 2 tracking as per needed
- Update HMIS tools as per the needs of programme divisions and centers.

HMIS running on DHIS2 platform is one of the ICT friendly platform with highly scalable features is being used to manage health sector information in an integrated and comprehensive manner, also used as one door system as recommended by health policy, public health act, public health service regulation and cabinet decision.

After the revision of HMIS tools in FY 2078/79, 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 volunteers (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

HMIS reports are collected at the time of monthly meeting in 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 district) is organized on 8th day of every month.
- Monthly review meeting is regularly organizing at district level on the 15th day of every month, which is the major innovation of the HO, Rolpa.
- The agendas of the meeting are program achievements, weakness, issues, challenges and major innovation to accomplish the basic health services from local level.
- Besides this, the agendas for the meeting are regularly providing by HO to LLG.
- Total 79.36% of HFs in the district currently doing online reporting via DHIS II platform and have planned to scale up to cent percent via online platform.

HMIS Reporting Status : FY 2080/81

Name of LLG	No. of HF (GoN/private/NGO)	No. of HF reporting Online	% of self reporting by HF in DHIS II platform
Thabang RM	9	9	100
Gangadev RM	9	9	100
Madi RM	10	10	100
Tribeni RM	7	7	100
Runtigadhi RM	12	12	100
Sunil Smriti RM	11	10	90.90
Paribartan RM	10	9	90
Rolpa Mun.	24	17	70.83
Lungri RM	20	10	50
Sunchhahari RM	14	7	50
Total	**126**	**100**	**79.36**

Reporting Status Dataset -: Shrawan 2080 to Ashad 2081

Name of LLG	Expected Reports	Actual Report	Reports on Time	Reporting rate	Percent on Time
Sunchhahari RM	84	84	84	100	100
Thabang RM	96	96	96	100	100
Paribartan RM	108	108	108	100	100
Gangadev RM	108	108	108	100	100
Madi RM	96	96	96	100	100
Tribeni RM	84	84	84	100	100
Runtigadhi RM	132	132	132	100	100
Sunilsmriti RM	96	96	96	100	100
Lungri RM	120	120	120	100	100
Rolpa Mun	204	204	202	100	99
District	**1128**	**1128**	**1126**	100	99.8

Management related activities carried out in FY 2080/81

- Prepared, printed and distributed the Annual Health Report
- HMIS and DHIS-2 training to local level's health workers to establish and improve the online reporting mechanism
- Monthly, Quarterly and Annual performance review and data verification workshop in each municipal level as well as district level
- Prepare monthly meeting agendas for LLG
- Onsite 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

5.6: FINANCIAL MANAGEMENT

An effective financial support system is imperative for efficient management of health services. 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. 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 is released in health office by Ministry of Health under Lumbini Province Government.

HO, Rolpa has a finance section, functional with an Account Officer. District planning of annual budget preparation has been carried out at second quarter and annual planning was submitted to higher authority through health directorate based National Health Policy & Programs in the designed format of National and Provincial Planning Commission. There is still a consistent problem of timely release of funds that has affected the implementation of health program.

Almost all of the financial irregularities (Beruju) have been cleared or submitted for clearance. No additional financial irregularities since last 6 fiscal years in HO Rolpa. It is major strength of HO Rolpa.

Total Budget and Expenditure at HO, Rolpa in FY 2080/81

SN	Budget	Budget Release (RS)	Budget Expenditure	Expenditure %
1	Current budget fiscal equalization grant	19296037	16903572.70	87.60
2	Current budget conditional grant	2889000	22076740	76.42
Total		**48186037**	**38980312.70**	**80.90**

आ.व.२०८०/८१ बार्षिक प्रगति विवरण (स्वास्थ्य कार्यालय, रोल्पा) (बजेट रु ०००)

सि.नं	कार्यक्रम खर्च विवरण	आ.व. अन्तिम बजेट	खर्च	वित्तीय प्रगति %	भौतिक प्रगति %	कै.
पुजीगत तर्फको खर्च (रकम रु हजारमा)						
1	स्वास्थ्य कार्यालयहरु (३७००१०१३४)	850	847.1	99.7	100	
2	परिवार कल्याण कार्यक्रम (संघ शसर्त अनुदान) (३७०९११३१४)	300	299.0	99.7	100	
क	**जम्मा**	**1150**	**1146.1**	**99.7**	**100**	
चालु तर्फको खर्च (रकम रु हजारमा)						
1	महामारी रोग नियन्त्रण कार्यक्रम (संघ शसर्त अनुदान) (३७०९११३२३)	1450	1297.3	89.5	100	
2	स्वास्थ्य व्यवस्थापन कार्यक्रम (संघ शसर्त अनुदान) (३७०९११२४३)	1165	1164.2	99.9	100	
3	उपचारात्मक सेवा कार्यक्रम (संघ शसर्त अनुदान) (३७०९११२७३)	1300	1298.9	99.9	100	
4	नर्सिङ तथा सामाजिक सुरक्षा सेवा कार्यक्रम (संघ शसर्त अनुदान) (३७०९११२८३)	1150	1149.7	100.0	100	
5	अपाङ्गता रोकथाम तथा कुष्ठरोग नियन्त्रण कार्यक्रम (संघ शसर्त अनुदान) (३७०९११३०३)	140	131.0	93.6	100	
6	क्षयरोग नियन्त्रण (संघ शसर्त अनुदान) (३७०९११२०३)	696	675.6	97.1	100	
7	एकीकृत स्वास्थ्य तथा सरसफाई कार्यक्रमहरु (३७०००० १२३)	5650	5260.9	93.1	100.0	
8	परिवार कल्याण कार्यक्रम (संघ शसर्त अनुदान) (३७०९११३१३)	22389	15761.7	70.4	97.38	
9	एड्स तथा यौनरोग नियन्त्रण (संघ शसर्त अनुदान) (३७०९११२१३)	300	299.3	99.8	100	
10	स्वास्थ्य कार्यालयहरु (३७००१०१३३)	12796.04	10795.5	84.4	100	
ख	जम्मा	47036.037	37834.2	80.4	99.740	
कुल जम्मा		**48186**	**38980.3**	**80.9**	**99.78**	

SUPPORTING PARTNER

6.1. The United Nations Population Funds

The United Nations Population Funds (UNFPA) is the United Nations sexual and reproductive health agency in Nepal. It has a global mission to deliver a world where every pregnancy is wanted, every childbirth is safe and every young's potential is fulfilled.

The UNFPA has set three transformative results to achieve SDGs by the end of 2030. These are zero unmet need for family planning, zero preventable maternal death, and zero gender based violence and harmful practices such as child marriage.
It has set the targets and outcomes in line with the national priorities and plans, ICPD commitments, ICPD+30 and local priorities. The UNFPA in Rolpa has been working to bring the positive outcomes in the lives of women and girls through developing partnership and collaboration with the government, civil society and local organizations since 2010.

Current pogrammes/projects in Rolpa district
SRH and GBV in emergency (Direct Cost)

S.N	Activity	Target	Achievement	Budget (lump sum)
1	Health and Protection Cluster meeting (SRHiE)	2	2	50,000
2	Support for Health policy formulation of Rolpa municipality	1	0	2,50,000

Partner-NRCS

S.N.	Activity	Target	Achievement	Budget (lump sum)
1	Formulation of DPRP (SRHiEm & GBViE)	1	1	50,000
2	Formulation of Local DPRP -two local units (SRHiEm & GBViE)	2	0	4,00,000

Adolescent friendly Sexual Reproductive Health (ASRH)

Adolescents' sexual and reproductive health is the foremost priority of UNFPA in Nepal. The United Nations Population Fund-UNFPA- has been working in comprehensive ways to increase the access of adolescents in adolescent friendly sexual and health services aiming to decreased the unmet need of family planning among young people and to promote adolescents' informed choice of family planning services.

As a part of promoting ASRH in Rolpa, it has joined hands to develop partnership and collaboration with the relevant government agencies, local government and likeminded organizations to create adolescent friendly sexual and health services, to attain the 3 transformative results set by the UNFPA and to ensure the adolescents' right to choice to achieve SDGs by 2030 in Nepal; based on the standard protocol, existing policies and plans.

Partner-ADRA Nepal

S.N.	Activity	Target	Achievement	Budget (lump sum)
1	Facility based annual review meeting of AFHS center	26	26	1,00,000
2	Basic Health logistics and supply chain management orientation	1	1	50,000
3	Quantification and forecasting training to health coordinators and responsible authority of Palika (LG)	1	1	50,000
4	Joint monitoring of AFHS and certification	3	0	60,000
5	Orientation to FCHV/MGs/AFSCC	3	0	50,000
6	5 days ASRH TOT	5	5	90,000

Partner-FPAN

S.N.	Activity	Target	Achievement	Budget (lump sum)
1	IUCD Batch	1	1	70,000
2	Implant	6	6	1,00,000

Partner-MIDSON

S.N.	Activity	Target	Achievement	Remarks
1	MNH clinical update	2	2	50,000

Global program for Ending Child Marriage (ECM)

The global programme to end child marriage is a joint initiative of UNFPA and UNICEF in Nepal to end harmful practices-child marriage through strengthening services and coordinated efforts based on the national commitments made to achieve SDGs.

In Nepal, harmful practices are persistent behaviors practiced by the one who possess the power victimizing the powerless, perpetuating the discrimination based on sex, gender, cast/ethnicity, language, religion and vice versa. The impact of these discriminatory practices leaves the women, girls, minority and the people from excluded groups at high risk violence, poorer physical and psychological health limited educational and economic outcomes, suicide and even death.

The UNFPA is working to end child marriage in Rolpa in partnership and collaboration with the government, civil society, likeminded I/NGOs, adolescent and communities.

It has adopted six key strategies to end child marriages:

- Empower adolescent girls at risks of and affected by marriage
- Provide quality education for girls
- Mobilize families and communities to change social norms
- Ensure health, education, protection and other systems are responsive to the needs of girls
- Engage men and boys
- Support government to create a positive legal and policy environment to end child marriage

Partner-VSO-Mahuri Home

S.N.	Activity	Target	Achievement	Budget (lump sum)
1	Rupantaran groups of girls (SRH sessions)	18	18	10,08,000
2	Rupantaran groups of boys (SRH sessions)	22	20	4,00,000
3	Rupantaran ToT (7 days)	1	1	5,00,000
4	Quarterly review and reflection meeting (mentoring) peer educators	3	2	1,00,000
5	Orientation to religious leaders, traditional healers and faith based priest	5	5	2,50,000
6	Rupantaran groups visit to adolescent friendly health service center (AFHS)	20	3	60,000
7	Interaction with CPSW, FCHV and mothers group	20	0	4,00,000
8	Interaction with parents with technical support of health worker of nearby HP	20	0	4,00,000

6.2. Kapilvastu Integrated Development Services

Kapilvastu Integrated Development Services (KIDS) non-government women led organization dedicated to fostering an equitable, healthy, and self-reliant society through comprehensive and inclusive development programs. Established in 2005, KIDS operates out of its central office in Kapilvastu with branch offices in Butwal, Nawalparasi-West, and Surkhet. Committed to assisting marginalized groups by enhancing their access to essential social services such as education, health, and livelihoods, and by empowering them with knowledge and skills for sustainable economic security.With a focus on gender equality and social inclusion, KIDS implements various programs in sectors like reproductive health, tuberculosis, and HIV/AIDS, nutrition and women empowerment across multiple districts in Nepal. KIDS is currently implementing a diverse range of programs aimed at addressing critical health and social issues in Nepal.In Rolpa UNFPA and IPAS supported SRHR program and Global Fund/Save the Children Supported TB Program running.

Goal: Establishment of Equitable, healthy and self-resilient Society

Strengthening Sustainable Sexual and Reproductive Health and Rights (SRHR) program (IPAS NEPAL)

KIDS in partnership with Ipas Nepal is implementing **Strengthening Sustainable Sexual and Reproductive Health and Rights (SRHR) Program** in three districts of Lumbini Province, viz. Pyuthan, Rolpa and Rukum East. The main goal of the program is to develop an innovative and dynamic approach and goes strategic shift to achieve and to ensure, free, quality, and sustained SAS services to women and girls of reproductive age. The objective also includes strengthen the health system pathways and capacity to ensure improved access, availability, quality, and acceptability of responsive and sustainable Sexual and Reproductive Health and Rights (SRHR) services. This program mainly focuses on such areas Sexual and reproductive health and rights (SRHR), Safe Abortion, Climate change and Gender.

In Rolpa district, this program is being implemented in Paribartan and Sunchhahari Rural Municipalities. The program duration is from FY 2024 to 2026, and the target group includes adolescents and women of reproductive age.

Activities conducted FY 2080/2081 (Dec 2023 to June 2024)

S.N.	Major Activities	Achievement
1.	Natural Leaders' (NLs) selection and basic training on SRHR (5 days)	1 Event
2	NLs community session on SRHR (Focusing on unreached area)	86 Community session
3	Social Movement and campaign on SRHR issues	16 Events
4	Capacity building training of Adolescent and Youth on SRHR (3 days)	1 Event
5	Engagement and mobilization of Adolescent and youth on SRHR program at community and school level	9 Events
6	Conduct community interface dialogue using CHSB for increasing accountability and service access to marginalized women and girls on SRHR and SAS	1 Event
7	FCHV orientation in SRHR and SAS	4 Event

8	Radio broadcasting for community awareness on SRHR and SAS	6 Months
9	Local Planning Advisory Committee (LPAC) meetings	2 Events
10	Policy discourse with elected women members at local level	2 Events
11	Interaction with local level government for policy formation budget allocation, utilization, listing process and mentorship	2 Events
12	Strengthen HFOMC for responsive SAS implementation	4 Events
13	MA training (5 person)	1 Event
14	Formation and training of rapid response team (6 person)	1 Event
15	Coordination meeting and technical assistance for DDMC-Biannual	Shifted to next Quarter
16	Coordination meeting and technical assistance for LDMC	1 Event
17	SNCIDRA assessment and health facility assessment	All ward and all HFs of both RM
18	MA Drugs and Logistics supply	4 health facilities
19	Wall painting with SAS logo in SAS implementing Health facility	3 health Facilities

SRHR program supported by UNFPA

Activities implemented under SRHR program supported by UNFPA at Rolpa district (Started from March, 2024 till date):

- Implant training provided to two health service providers, one from Rolpa Municipality and one from Sunilsmriti Rural Municipality.
- Supported 1 event of RHCC meeting
- Conducted pre-planning meeting with budget formulation committee of Rolpa Municipality
- Provided support to print out health policy of Rolpa Municipality

Upcoming activities (Till December, 2024):

- FP micro-planning workshop at Sunilsmriti Rural Municipality
- Support to one event of RHCC meeting
- Onsite coaching on eLMIS to strengthen logistics management system

National Tuberculosis Control Program

Nepal Government had implemented National Strategic Plan 2021/22-2025/26 objective of controlling Tuberculosis in collaboration with Nepal Government, Global Fund and Save the Children in coordination with Partner Organization.As a sub receipient organization KIDS Nepal implementing NTP in Lumbini and Karnali Province.

NTP program is implemented in 9 districts of Lumbini Province i.e. Rolpa, Rupendehi, Nawalparasi-West, Kapilvastu, Dang, Bardia, Pyuthan, Palpa and Banke and also implemented in 4 districts of Karnali Province i.e. Surkhet, Salyan, Dailekh and Kalikot.

Major Activities:

- Establishing sputum courier system for TB case detection in hard to reach population and transporting the sample to microscopic and Genexpert.
- Contract tracing of all PBC Bacteriological conformed and all cases of child under 15 years (PCD/PBC/EP) and screening of all family members who were in contact with index case.

- Transportation of sample of suspected DR-TB cases at Genexpert center for screening and testing of all DR-TB suspects.
- Contract tracing of all DR TB confirmed cases and screening of all family members who were in contact with index case.
- Supporting in TB screening among malnourished and ARI children in Outreach clinic/ Health Facilities/ Major Hospitals.
- Establishment and continuation of Preventive therapy for children under 5 Isoniazid Preventive Therapy/ Tuberculosis Preventive Therapy (IPT/TBPT).
- Conducting household members screening and organize Active Case Finding (ACF) mobile camp in community.
- Conducting Onsite coaching and supportive Supervision at Health facilities.

Supportive Activities:

Supporting activities for the implementation of NTP National Strategic Plan 2021/22-2025/26 in Rolpa District are as follows: -

- Technical Support provides in all local level on TB related HMIS, DHIS2 and eTB.
- Orientation provided to the local level representative and focal persons.
- Technical support provide to all ten local level on Tuberculosis management.
- Technical support provide to TB free movements.

Achievement Shravan 2080 to Asar 2081

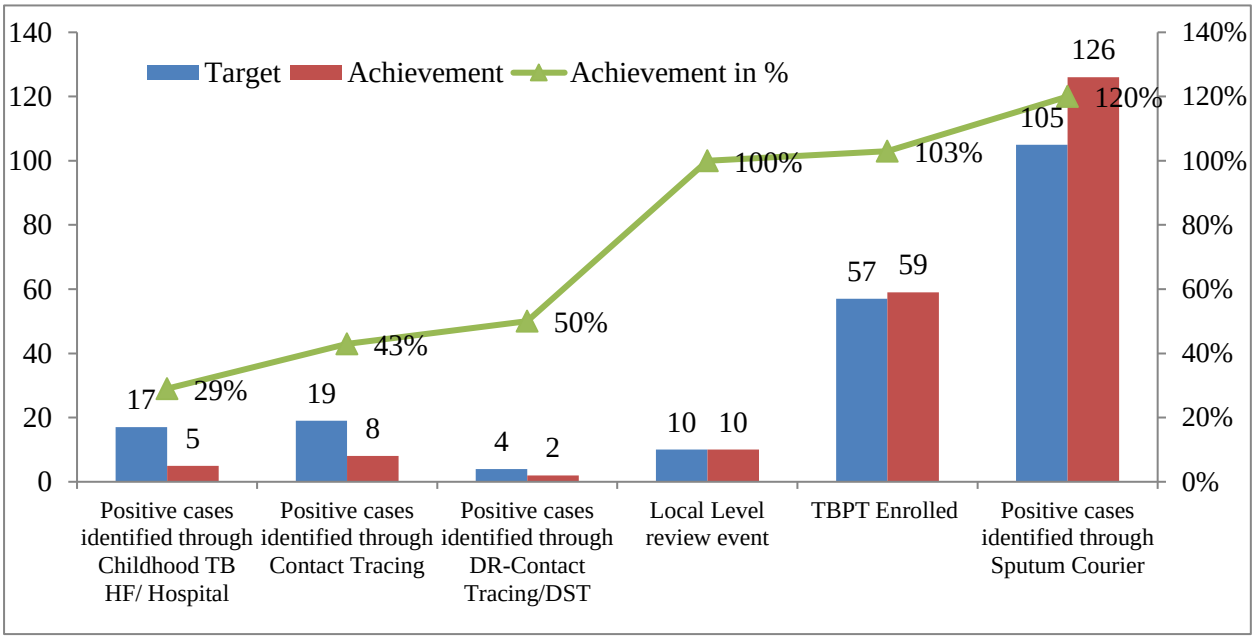


Figure: Target Vs Achievement 2080/81

6.3. Nick Simons Institute

Nick Simons Institute (NSI) is a non-government philanthropic Organization established on 2006 that works in close collaboration with the Federal and Provincial Ministry of health in expanding curative health care services in rural areas of Nepal. Currently, NSI has been supporting CSSP programs in 40 government hospitals and 17 hospitals as training sites.

The Operating Principles of Nick Simons Institute are:

- Collaborate closely with the Government of Nepal, the main rural healthcare provider.
- Extend beyond training, to include workplace support and advocacy.
- Select strategic training cadres, which involve 'task-shifting' from traditional medical roles.
- Innovation in evidence-based research

Mission

To innovate solutions in rural healthcare through training and hospital support, and to advocate for their scale-up with the government of Nepal.

Vision

People in rural Nepal receiving quality healthcare services within their own communities

Objectives

- Improve the healthcare services to the people residing in rural areas.
- Develop and expand programs to solve the health issues in rural areas.

Program Areas

- Curative Service Support Program (CSSP)
- Hospital Strengthening Program (HSP)
- Training
- Research/ Advocacy

Activities in Rolpa District on FY 2080/2081

a) **Human Resource Support**

Nick Simons Institute supported different clinical staff in Rolpa Hospital during the last fiscal year. The following Human Resources were supported in Rolpa Hospital:

- MDGP-1
- Medical Officer -1
- Anesthesia Assistant -1
- Staff Nurse 1
- Biomedical Technician -1
- Nursing Officer -1 (partial support)

b) Equipment Support

c) As a part of equipment support, different equipment needed for the hospital such as an Automated External Defibrillator, KMC Chair, Fetal doppler machine, and cautery machine was supported to Rolpa Hospital last fiscal year.

d) Quarter Support

For the comfortable living of hospital staff, rent for the hospital quarter, internet, and furnishing of the quarter was supported.

e) Training

Different types of clinical training such as Skilled Birth Attendant (SBA), Operation Theatre Management Training (OTTM), Essential Critical care Training (ECCT), Mid-level Practicum Training, Primary Emergency care (PEC) training was provided to clinical staffs at Rolpa hospital last fiscal year.

6.4. Rural Development and Awareness Society Nepal

RUDAS Nepal is a solely service-oriented non-governmental organization. It was affiliated with the Social Welfare Council (SWC), Nepal with affiliation No. 17550/061/062.

From the date of establishment, the organization has been working with the target communities rigorously and continuously, sometimes being volunteer and most often the time with the help of different funding Agencies.

RUDAS Nepal is devoted to community development activities and is being engaged in profuse types of social, rural development, empowerment, poverty, agriculture, and livelihood promotion works refocusing rural and unapproachable communities. The organization played a vital role in ensuring human rights and fundamental human needs in the climax of armed conflicts in civil war. Sounds technical knowledge and skill on gender and social inclusion, and food security through commercial agriculture and livelihood furthermore, Health and Nutrition activities are the major achievements. It has golden working experiences in technology dissemination in agricultural and livelihood community development, empowerment, market management, value chain development, and community mobilization work in farming.

The organization plays the best bridging role between stakeholders, which have plans and resources to address these issues/challenges at the grassroots level. All achievements come from competent leadership in the executive body and staff, financial and Behavior Change Communication (BCC), and Decent coordination with stakeholders. An effective system for monitoring and backstopping, qualified staff and members with clear responsibility and accountability

Furthermore, to uplift the living standard of marginalized groups including ultra-poor people, women, Dalits, and Janajati society, it has aimed to improve agribusiness and small enterprises in rural areas.

The organization has been providing services in health, agriculture, Education, and infrastructure development. The organization is also conscious of the climate, environment and health and Nutrition issues and has experience in sanitation, health campaigns, and HIV/AIDS.

The organization is visionary, efficient, dedicated, competent, and dynamic leadership. The executive committee comprises members from diversified communities and groups that play vital roles in participatory and grassroots democracy in an organization and its surroundings.

USAID-ARH (Adolescent Reproductive Health) by RUDAS Nepal

USAID Adolescent Reproductive Health (ARH) is a five-year program supported by the U.S. Agencyfor International Development (USAID). Led by CARE Nepal and in partnership with Howard Delafield International (HDI), Jhpiego, Association of Youth Organizations Nepal (AYON), and Nepal CRS Company, USAID ARH is an initiative to empower girls and boys 10-19 years of age, including the most marginalized, to attain their adolescent reproductive health rights. The project ensures the full participation of adolescents in the design and implementation of all activities. The primary goal of USAID ARH is to support adolescents to reach their full potential and strengthen public systems and private entities to create an enabling environment for healthy ARH behaviors through its three objectives:

1. Provide accurate, relevant FP/RH information and behavior change support to adolescents; and educate their parents, teachers, and communities, addressing current social norms for adoption of healthy reproductive health behaviors.
2. Improve availability and accessibility of quality FP/RH services for adolescents by identifying addressing key gaps in current services and in systems that determine effective access and utilization of adolescent-friendly services and products
3. Institutionalize successful data-driven approaches and mechanisms addressing adolescent reproductive health through the public and private sectors by improving health system governance.

USAID ARH will contribute to a healthy, resilient, well-nourished population in Nepal. The project covers 60 municipalities (15 rural, 45 urban) of which 41 municipalities (415 wards) are across 6 districts in Madhesh Province, 12 municipalities (94 wards) across 3 districts in Lumbini Province, and 7 municipalities (87 wards) across 2 districts from Karnali Province. Of the total 596 wards, the project will work intensively with 360 wards and less intensively with the other 236 wards across these 60 municipalities.

Major Achievements

- Aiming for SBCC, 108 SAA groups have been formed in the community and School focusing on Adolescents,
- Young Mothers, Adolescent Fathers, and Mothers. Among 2521 Group members. Furthermore, to catalyze SBCC in ARH, quarterly meetings for Social Leaders/Religious had been conducted.
- To improve the Governance System Strengthening in the Health sector, the AFHS Coordination Committee (AFHS CC) was conducted in each working Rural/Municipality with 11 members in each AFHS CC. It assisted in deciding activity implementation in the working location or community as needed.
- Concerning better health or awareness in the community, Orientation on the FCHVs modular package was done to 55 FCHVs, who will further carried out the same activity in the Health Mothers Group (HMG). Another SATH activity had been conducted among 453 HMG members from 12 HMG.
- To provide quality Health service, **HUB AND SPOKE MODEL OF MENTORSHIP** was done in Rolpa Hospital as a Hub site and to 8 spoke sites. 31 whole site orientations following AFS Guideline 2079. In each Health facility, 16 QA/QI Assessments were done for service quality improvement
- For Advocacy and Managing the ARH Issue/Challenges to work on policy, strategy, and planning technical assistance was provided and GESI Policy was formed in Rolpa Municipality. Similarly, End Child Marriage Strategy and the Health Policy were in progress in Lungri Rural Municipality.
- To eliminate or eradicate GBV and discrimination and for advocacy, awareness, and Rights of Adolescents and Youth, various celebrations like Youth International Day, Children's Day, Women’s Day, and Adolescent Campaign were done.

- USAID-ARH also focused on youth mobilization activities, and 6 youth clubs were formed and, 12 Quarterly review reflection and planning meetings were done. Furthermore, 8 ward-level advocacy campaigns on Adolescent and Responsive Family Planning were executed in municipalities and adolescents and young mothers were participated and facilitated by youth.
- Adolescents Assembly was conducted at Lungri Rural Municipality for concerning adolescent and youth-related issues and challenges, moreover proposal was submitted by youth club members to the Rural Municipality Chairperson for youth and adolescents focused program and Budget allocation
- Adolescents and Stakeholders had received adolescent reproductive Health services through 18 eligible private Health facilities. 5 days of training on ASRH, 3 days of Sangini Training, 1-day reporting and recording training had been conducted in private health facilities. Whole site orientation at three sites on FP/ARH at private health facilities were done where 34 participants were orientated about the adolescent sexual and reproductive health, Adolescent friendly health services, Myths related to Family Planning, obstacles faced by adolescent while receiving the reproductive and family planning services in health. We aim to make each private and public health facilities to provide adolescent-friendly health service.

Budget

S.N.	Name of Projects	Budget	Expenditure
1.	USAID-ARH	2,09,24,923	1,41,04,633

6.5. Medic Mobile

मेडिक मोबाइल (Medic Mobile) मोबाइल प्रविधिमा काम गर्ने गैह्र नाफा मुलक संस्था हो। यस संस्थाको मूल उदेश्य दुर्गम क्षेत्रमा मोबाइल प्रविधि मार्फत मातृ तथा बाल स्वास्थ्य सेवा प्रवाहमा समन्वय बढाई मातृ तथा शिशु स्वास्थ्यमा सुधार ल्याइ मातृ तथा शिशु मृत्युदरमा कमि ल्याउनु हो। यस संस्थाले स्वास्थ्य कार्यालय रोल्पा र सबै स्थानीय तहहरुसंगको सहकार्यमा रोल्पा जिल्लाको १० वटा स्थानीय तहहरूमा मोबाईल स्वास्थ्य कार्यक्रम संचालन गरिरहेको छ।

यस सन्दर्भमा समुदाय स्तरमा मातृ तथा बाल स्वास्थ्य सेवा दिनुहुने महिला स्वास्थ्य स्वयंसेविकाहरु र सम्बन्धित स्वास्थ्यकर्मीहरुले गर्ने काममा पनि व्यवस्थित रुपमा मोबाईल प्रविबिधिको प्रयोग गरी मातृ तथा बाल स्वास्थ्य सेवा प्रवाह र तिनका सूचांकहरुमा सुधार ल्याउने उदेश्यका साथ मोबाईल स्वास्थ्य कार्यक्रम लागु गरिएको हो। यस कार्यक्रम अन्तर्गत कुनै छुट्टै क्रियाकलाप नभई म.स्वा.स्व.यंसेविकाहरु र स्वास्थ्य संस्थामा रहेर काम गर्ने स्वास्थ्यकर्मीहरुले पहिले गरिरहनु भएको कामहरुलाई मोबाइल मार्फत अझै छिटो र प्रभावकारी बनाउन सहयोग पुग्नेछ ।

मेडिक मोबाईल, स्वास्थ्य कार्यालय, रोल्पा तथा जिल्लाको सबै स्थानीय तहहरूसंगको समन्वयमा मातृ तथा बाल स्वास्थ्य सेवा समन्वयका लागि मोबाईल स्वास्थ्य कार्यक्रम जिल्लाभरी संचालन गरिएको छ। यस बर्ष रोल्पा जिल्लाको १० वटा स्थानीय तहको १०० भन्दा बढी स्वास्थ्य संस्थाको २०० जना स्वास्थ्यकर्मीहरूलाई मोबाइल स्वास्थ्य प्रशिक्षक प्रशिक्षण तालिम दिइ उहाँहरू मार्फत ४५९ जना महिला सामुदायिक स्वास्थ्य स्वयमसेविकालाई तालिम प्रदान गरी गर्भवती महिलाहरूलाई दर्ता गरी सेवा शुरुवात गरिएको छ ।

यस कार्यक्रमको मुख्य उदेश्य गर्भवती महिलाको समयमै आठ पटक गर्भजाँच गराउने, स्वास्थ्य संस्थामै सुत्केरी गराउनु, तथा सुत्केरी अवस्थामा आमा र नवजात शिशुको नेपाल सरकारले तोकेको समयमा जाँच गराइ जोखीम न्युनिकरणमा सहयोग गरी आमा र बच्चाको मृत्यु हुनबाट बचाउने रहेको छ।

यस बर्ष सम्पन्न कृयाकलापहरू

क्र.सं	कृयाकलाप	सहभागी
१	गाउँ/नगरपालिका स्तरीय अभिमुखीकरण	गाउँ/नगरपालिकाको स्वास्थ्य शाखाबाट संयोजक, सह-संयोजक र सबै स्वास्थ्य संस्थाबाट १/१ जनस्वास्थ्यकर्मीहरु
२	गाउँ/नगरपालिकार स्वास्थ्य संस्था स्तरीय २ दिने प्रशिक्षक प्रशिक्षण	१० वटै पालीका
३	सामुदायिक महिला स्वास्थ्य स्वयमसेविकाहरूलाइ २ दिने तालिम र संचार खर्च वितरण	म.स्वा.से

6.6. Birat Nepal Medical Trust Nepal

BNMT Nepal is a Nepalese non-governmental organization dedicated towards the improved health and well-being of Nepalese people. BNMT Nepal is built on the foundation, expertise and experience of Britain Nepal Medical Trust UK with commendable history of serving the people of Nepal since 1967. Since its inception, BNMT Nepal continues to support the Government's interventions on tuberculosis, sexual and reproductive health and rights, mental health, child health, maternal health and to combat other diseases. BNMT's work covers strengthening the capacity of local institutions in responding to community health needs, empowering communities, especially disadvantaged groups, in accessing and advocating for increased, improved, and equitable access to essential health services and developing innovative models and approaches that provide affordable and accessible quality health care services. These principles have embedded into the practice of BNMT Nepal.

Vision Improved health and wellbeing of Nepalese people **Mission** To ensure equitable access to quality health care and enabling environment for socially and economically disadvantaged people. **Focus** Health, climate change and environment contributing to improved health, livelihood and social harmonization.	**Working Principles** • Adhere to and appreciate partnership at all levels • Ensure Sust ainable Development • Respect for Equity and Diversity • Promote Transparency and Accountability **Working Approaches** • Human Rights Based • Partnerships and Alliance • Partiipatory Gender and Social Inclusion

BNMT Current Program in district

Project Title	Reconstruction and strengthening of sanitation and hygiene at health facilities in remote earthquake affected areas of Rolpa District, Nepal (RESPOND II)
Project Goal	Reconstruction and strengthening of sanitation and hygiene at health facilities
Input	• Evaluation and prioritization of WASH infrastructure at 5 health posts and birthing centers in Rolpa district, including district hospital. • Repair and strengthening of WASH facilities at 5 health facilities and birthing centers, serving a total population of 224,793 beneficiaries. • Provision of strengthened water supply infrastructure at health facilities to support infection control, sanitation, and hygiene practice • Provision of dignified, gender friendly toilet facilities for staff and clients of five health facilities and birthing centers • Repair of tiling, piping, wiring and stair access to improve safe and dignified WASH facilities for staff and clients at health facilities
Project Area	• Rolpa District: - We anticipate the project will primarily cover five health facilities and birthing centers: Rolpa District Hospital, Lingdung health post, Dhabang health post, Khamel health post and Mirul health post.
Funded By	• Americares

Project Period	• April- November 2024 (Eight months)
Working Approach	• Partnership and Participation
Target Groups	Target beneficiaries will be staff and community utilizing the health facilities, which includes women attending five birthing centers along with children attending for acute and routine health services. Rolpa district has 49 health posts, 1 primary health center and 1 district hospital serving a population of 224,793. There are additional peripheral health facilities including 22 basic health service centers and 34 community health units.
Key Interventions	• Consultation meeting with government and other concerned stakeholders • Approval obtained from Social Welfare Council (SWC) • Meeting with HO/Palika and share the project and received authorized documents. • Consultation and preparation of report on WASH in health facilities of Rolpa district • Finalization of priority repair and reconstruction sites and scope of work with district health office and municipal stakeholders • Competitive procurement of materials and contractors • Reconstruction and repair works • Monitoring and evaluation of installations • Evaluation and monitoring report • Social welfare council report and dissemination meeting • Documentation and reporting
Key partners and stakeholders	• HD, Health Office, District Hospital, Water supply and sanitation unit, Local Level Government, Local NOGs,
Expected outcome	• Strengthened WASH infrastructure at health facilities serving a total population of 224,793 people in remote rural Rolpa district of Nepal. • Improved community health facilities for vulnerable population, including pregnant women, infants and elderly will enable vulnerable population to utilize local community health centers with confidence and avoid travel to more remote sites. • Availability of reliable water supply for infection control, basic sanitation, and hygiene at five health posts and birthing centers will improve health outcomes. • Safe and dignified basic toilet facilities for staff and clients at health posts will increase utilization of the health facilities and allow female staff and clients to achieve dignified menstruation. • Improved WASH facilities will improve working conditions for community health staff, particularly for menstruating women, and increase staff retention. • Improved water supply and handwashing facilities will improve infection control practices and reduce transmission of infectious diseases,

	secondary infections, and antimicrobial resistance.

Health Facilities wise action Completed

SN	HF Name	Activities Name
1	Rolpa Hospital	Plantation for Safe drinking water, Wall Painting the WASH related Information
2	Mirul Health Post	Tilling in all basement of health post and installation of water tank and Basin and completed the Soak Pit
3	Lingdung Basic Health Service center	Tilling in delivery room, Maternity room and toilet, constructed attached toilet in delivery room, Constructed the 2 room building, Gipson fixed in delivery room and maternity room, Basin installation in delivery room and Plaster in base and Wall Painting for health education
4	Dhabang Health Post	Delivery bed installation, Basin installation in delivery room and dressing room, New door installation in toilet, Fixed the basin pipe in toilet, Installation the high voltage wire for electricity, manage the waste water tank, Provide the heater.
5	Khumel Health Post	Placing zinc sheets on the roof, tilling in delivery room and toilet, Plaster in irrupted area, Color Painting in wall
6	Health Office, Rolpa	Smart Educational Board Installation, Filter and 2 Dispenser for Safe Drinking Water, Painting and support to other activities

Other Completed Activities

S.N.	Activities Name	No. of participants/No of received commodities
1	2 days IPC Orientation to the Nursing staffs and Office Assistant	28 Person
2	One day orientation to the FCHV of Rolpa Municipality	30 Person
3	Provide IPC related Commodities to the Nursing staffs and Office Assistant	28 set
4	Provide Hygiene Kit to the FCHV	30 set

6.7. Helen Keller International, Nepal

Helen Keller International 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, build capacity of organizations and contribute to policy changes through systems strengthening and operations research.

Multiple Micronutrient Supplementations (MMS) for Pregnant and Lactating Women in Nepal: Implementation Research

Nepali women currently receive iron and folic acid (IFA) supplements during pregnancy and postnatal care. However, research indicates that multiple micronutrient supplements (MMS) offer superior benefits for maternal and infant health. The Ministry of Health and Population (MoHP) is exploring a shift from IFA to MMS but requires evidence on acceptability, adherence, and the feasibility of the transition.

Prior to launching the research activities, Helen Keller International, in leadership of the Family Welfare Division, organized a two-day stakeholders' meeting to introduce the MMS project. Representatives from the Ministry of Health, UNICEF, WFP, and the Eleanor Crook Foundation discussed the MMS study, implementation priorities, and the IFA supply chain. The event reinforced a commitment to evidence-based strategies for a successful transition to MMS. Following this, a provincial stakeholders' workshop held in Lumbini on April 19, 2024, introduced the MMS study's implementation strategies, including facility randomization and MMS supply options. Sensitization workshops in 10 districts engaged local stakeholders, introducing the study, reviewing methodologies, and gathering feedback on the feasibility of training health workers.

To assess MMS acceptability and adherence, a comprehensive mixed-methods study is being conducted across all seven provinces of Nepal. In Lumbini province, a randomized controlled trial (RCT) is evaluating adherence to MMS (in both bottle and blister packaging) compared to IFA. In the remaining six provinces, a demonstration study is measuring MMS adherence and acceptability. Additional qualitative studies are being conducted to explore factors influencing acceptability and identify barriers to a smooth transition, based on interviews with policymakers, healthcare providers, and community health volunteers. Simultaneously, the Department of Drug Administration led a workshop to evaluate the transition from IFA to MMS, discussing the inclusion of MMS in Nepal's Essential Medicines List (EML) for sustainable implementation. Training sessions for research officers and research associates focused on study protocols, methodologies, and tools to ensure proficiency.

The MMS implementation research is progressing, and findings from these studies will provide critical evidence to support Nepal's transition from IFA to MMS, offering guidance for global stakeholders facing similar transitions.

6.8 Rural Reconstruction Nepal

नेपाल ग्रामीण पुनर्निर्माण संस्था एउटा मुनाफा रहित (आरआरएन), मानव अधिकार तथा सामाजिक विकास संस्थाको रुपमा कार्यरत संस्था हो । सन् १९८९ मा जिल्ला प्रशासन कार्यालय, काठमाण्डौमा दर्ता भई यसको विधिवत रुपमा स्थापना भएको हो । यस संस्था स्थापनाकालमा ग्रीट्स नेपालको नामबाट चिनिएको थियो भने पछि सन् १९९३ मा यसको नाम परिवर्तन गरेर नेपाल ग्रामीण पुनर्निर्माण संस्था–आरआरएन राखियो। यो संस्थाको शुरुआत

बाढी पीडितहरुलाई राहत तथा पुनस्थापनाको कार्यबाट भएको हो । यस संस्थाको केन्द्रिय कार्यालय काठमाण्डौमा रहेको छ चितवन, विराटनगर, संखुवासभा र नेपालगञ्जमा यसका स्रोत केन्द्रहरु रहेका छन्। यो संस्थाले हाल सम्म देशको १५ लाख घरपरिवार सम्म पुगेर विकासका कार्यक्रमहरु गरिसकेको छ ।

आरआरएनको परिकल्पना र ध्येयः

- आरआरएनले त्यस्तो विश्वको परिकल्पना गर्दछ, जहाँ सबै नागरिकहरु सामाजिक न्याय, समानता, शान्ति र समृद्धिका साथ बाँच्न पाउन् ।
- संस्थाको ध्येय अति गरीब ग्रामीण जनताहरु खासगरी ग्रामीण महिला, सिमान्तकृत किसानहरु र नेपाली समाजका अति विपन्न तथा सामाजिक रुपमा उत्पिडित मानिसहरुलाई उनीहरुकै सामाजिक आर्थिक सशक्तिकरणका अवसर उपलब्ध गराई उनीहरुको जीवन स्तरमा सुधार ल्याउनु हो ।

आरआरएनका उद्देश्यहरुः

- अति गरीब, उत्पिडित तथा जोखिमपूर्ण अवस्थामा रहेका समुदायहरुको सामाजिक–आर्थिक अवस्थामा सुधार ल्याउने।
- समस्या समाधान र तथ्याङ्क संकलन गर्नका लागि कार्यवाही उन्मुख अनुसन्धन गर्ने र समावेशी नीति तथा सुशासनको सुधार गर्न जनपोयोगी तथा ज्ञानोपयोगी प्रकासन तथा सामग्री उत्पादन, प्रसारण तथा वितरण गर्ने।
- गरिबी उन्मुलन, समावेशी विकास, मानवअधिकार संरक्षण लगायतका मुद्दामा स्थानीय, राष्ट्रिय, क्षेत्रीय र अन्तराष्ट्रिय पैरवी तथा अभियान संचालन गर्ने ।

लक्षित वर्ग तथा समुदायः

- यस संस्थाको लक्षित वर्ग तथा समुदायहरुमा ग्रामीण क्षेत्रमा वसोबास गर्ने अति गरीब, उपेक्षित तथा उत्पिडनमा परेका महिला, बालबालिका, दलित, जनजाति, मुस्लिम, मधेशी, अपाङ्गता भएका व्यक्तिः, साना तथा सिमान्तकृत किसानहरु पर्दछन् ।
- अझ स्पष्ट रुपमा भन्नु पर्दा सरकारी निकायको ध्यान नपुगेका क्षेत्र तथा समुदायहरुलाई संस्थाले लक्षित वर्गको रुपमा लिएर कार्यक्रम कार्यान्वयन गर्दछ ।

रोल्पा जिल्लामा संचालनमा रहेको परियोजनाको अवस्था

परियोजनाको नाम : नागरिक सशक्तिकरण मार्फत जोखिमपूर्ण समुदायको खाद्य तथा पोषण सुधार, रोल्पा)

कार्यक्रम कार्यक्रम अवधिःनोभेम्बर २०२१ देखि डिसेम्बर २०२४ सम्म

दातृ संस्था : BMZ/WHH,जर्मनी

साझेदार संस्थाः नेपाल ग्रामिण पुनर्निमाण संस्था आरआरएन

परियोजना संचालन क्षेत्रः रुंटीगढी गा पा (९ वडा)र त्रिबेणी(७ वडा), रोल्पा

कार्यक्रमको अनुमानित बजेटकरिब रु १२ करोड ३० लाखः

उपलब्धिहरु परियोजनाको उपलब्धिलाई परियोजना यही असार मसान्त सम्मको उल्लेख गरिएको छः जुन निम्नानुसार बुदागत रुपमा छन् :

- दुवै गाउँपालिकामा पाँच वर्ष मुनिका १२,८७० बालबालिकाको बालमापन ४३९ MAM केसेस फेला परेको र NERP क्याम्प मार्फत ९२.९५%मा झरेको,४ लटमा क्याम्प संचलान हुँदा घटेर MAM केसेस ४८ मा झरेको छ ।
- ९५% SAM केसेस रिकभर भएको छ ४४ SAM केसेस OTC मार्फत उनीहरु शुपोषित बाहेक हुन्

- बच्चाहरूको लागि न्यूनतम स्वीकार्य आहार ४९% पुगेको छ जबकि यो आधार रेखामा ४५.५३% थियो।
- ९६.६८% घरपरिवारले ३ थप खाद्य समूह बनाउन थालेका छन् ।
- खाद्य खपत सूचक (FCS) अझै पनि ७८% को आसपास स्थिर देखिन्छ, जबकि यो आधार रेखामा ६५.४६% थियो
- स्वदेशी बालीको प्रवर्द्धन र संरक्षणमा समुदायको चासो बढ्दै गएको देखिन्छ ।
- महिलाहरूकोलागि न्यूनतम आहार विविधता (MDD-W) ७२ पुगेको छ जबकि यो आधार रेखामा ५८.३०% थियो।
- MAM तथा SAM बालबालिकाहरूको अनुगमन (दुवै गाउँपालिकाको १६ वटा वडामा संचालन भएको छ)
- दुवै गाउपलिकमा लक्षित समूहहरूको लागि PLA LANN+ सत्रहरू ९६ समुहमा सम्पन्न भइ नियमित follow up भैरहेको छ ।
- त्यसैगरी ९६ समुहमा अशल कृषि अभ्यास (Good Agricultural Practice-GAP) GAP सेशनहरु संचालन भई सम्पन्न भएको र नियमित follow up भैरहेको छ ।
- रैथाने बालीहरूको संरक्षण र प्रवर्द्धन (५ वोटा तालिम),–किसान,स्वास्थ स्वयंसेविकाहरुलाई १६ पोषण नर्सरी स्थापना (प्रत्येक वड़ामा एउटा नर्सरीको लागी २ लाख बराबर अनुदान)
- कृषि सेवाग्राही र सेवाप्रदायक बीच अन्तरकृया कार्यक्रम -२ पटक भएको जसले कृषक र सेवाप्रदायक वीचको सम्बन्ध झन् सुमादुर हुदै गएको।
- असल कृषि अभ्यास सम्बन्धि प्राबिधिकहरुलाई तालिम–२ पटक सम्पन्न भएको र दुवै गाउँपालिकाका सबै वडामा कृषि कर्मको लागि किसानहरुलाई प्रत्यक्षआवस्यक सुझाब र सहयोग भैरहेको।
- किसानहरूलाई बीउ तथा सामग्रीहरू सहयोग (४३०५ घरधुरी, २६ किसीमका बिउ बिजन तथा कागती र सुन्तलाका विरुवा, अभोकाडो, हलुवाबेद अनार, स्ट्रबेरी बिरुवा, ८१ मल्चिंग, कोदो, फापर, गहत बिउबिजन, १६ टनेल प्लास्टिक
- विद्यालय, वडा र पालिका स्तरमा सचेतनामूलक गतिविधिहरू (१६ वडा, सबै विद्यालय र पालिकामा) सहभागितामूलक योजना तर्जुमा (पीपीपी) मा स्वास्थ्यकर्मी, सामुदायिक नेतृत्व, वडा/पालिका प्रतिनिधि कर्मचारीहरूको क्षमता अभिवृद्धि सिकाई आदानप्रदान भ्रमण कार्यक्रम – २
- सहभागितामूलक योजना तर्जुमा (पीपीपी) मा समुदायहरूलाई अभिमुखीकरण (१६ वडाको टोलहरुमा) विद्यमान सामुदायिक संस्था र सञ्जालहरू (महिला समूह, युवा समूह, Right to Food संजालहरु, आदि) को नक्साङ्कन र क्षमता मूल्याङ्कन (POCAP) (१६ संस्थाहरू
- सेवा प्रदायकहरूसँग सामुदायिक अंक पत्र लागू (१६ वडा /स्वास्थ्य चौकीहरू)
- महिला नेतृत्वहरूलाई वकालत तालिम (२ तालिम)
- पालिकाको खाद्य र पोषण स्थिति मूल्याङ्कन (पालिका, १६ वडा)
- पोषण नीति/योजनाहरूमा वार्ड/पालिका प्रतिनिधिहरू समुदायहरूलाई अभिमुखीकरण-७
- पोषण र खाद्य गुरुयोजना निर्माण र कार्यान्वयनमा सहयोग-१
- पालिकाको खाद्य र पोषण गुरुयोजनाहरूको साझेदारी र प्रमाणीकरण

6.9. रोल्पा प्लस

संस्थाको परिचय र स्थापनाः

वि.स.२०६५ चैत २० गते एच.आई.भि तथा एडस्सँग बाचिरहेका व्यक्तिहरुको स्वास्थयको हेरचाह र उनिहरुको हकहितको वकालतका लागि स्थापना भएको संस्था हो । यस संस्थाले हाल रोल्पा जिल्ला भित्र ६ वटा पालिकाका व्यक्तिलाई सेवा दिइरहेको छ ।

मिसन

मनोसामाजिक परामर्श, संक्रमितहरुको गुणस्तरिय जीवनका लागि काम गर्ने, एच.आई.भि परिक्षण र सुझाब

लक्ष्य

एच.आई.भि र्सक्रमित विरामीहरुको जिवन गुणस्तर सुधार गर्नुका साथै एच.आई.भि रोग संग बाचिरहेका मानिसहरुले सामाना गर्नु भएका समस्या र चुनौतीका बारेमा सम्बोधन र समाधान गर्ने ।

उदेश्य

१.जिल्लामा रहेका एच.आई.भि संक्रमितहरुको डाटा संकलन गर्ने छ ।

२.जनचेतना बाट एच.आई.भि एडस् संक्रमित र त्यहा रहेका रैथाने समुदायलाई समेट्ने गरी सहकार्यको माध्ययमवाट आफ्नो समस्या विश्लेषण तथा समाधानको लागि कार्य गर्न सक्ने क्षमताको विकाश गराई सरल जिवनयापन र स्वास्थ्यमा सुधार ल्याई एच.आइ.भि एडस् संक्रमणलाई राख्नु ।

३.अत्यधिक जोखिम पुर्ण अवस्थामा रहेका एच.आई.भि एडस् संक्रमित व्यक्तिहरुलाई जीवन रक्षा र तत्काल सुरक्षा प्रदान गर्ने हेतुले छोटो समयको लागि आपतकालिन सहयोग प्रदान गर्ने ।

४.समुदायमा एच.आई.भि तथा एडस् सम्बन्धि जनचेतना फैलाई एच.आई.भि तथा एडस् संक्रमित व्यक्तिहरुप्रतिको लान्छना तथा भेदभाव कम गर्ने ।

५.परिवार र समुदायिक स्तरमा एच.आई.भि बारेमा सामाजिक सकरात्मक बुझाई बढाउने ।

कार्यक्रमको नाम

ग्लोबल फण्ड एच.आई.भि केयर एण्ड सपोर्ट परियोजना

कार्यक्रमको कार्य क्षेत्रः

यस रोल्पा प्लस संस्थाको कार्य क्षेत्र रोल्पा जिल्ला रहेको छ ।

ग्लोबल फण्ड एच.आई.भि प्रोग्राम अर्न्तगत संचालित कार्यक्रमहरु

- हेरचाह तथा सहयोग कार्यक्रम (Care and Support Program)
- घर तथा सामुदायमा आधारित हेरचाह (Community and Home Based Care) CHBC

एच.आई.भि संक्रमित व्यक्तिहरुलाई उनिहरुकै घर तथा समुदायमा गएर प्रदान गरिने सेवालाई घर तथा समुदायमा आधारित हेरचाह भनिन्छ। घर तथा समुदायमा गएर संक्रमितको स्वास्थ्य अवस्था बारे बुझ्ने र परामर्श दिने गरिन्छ ।

CHBC सेवा

आ.ब	महिला	पुरुष	जम्मा
२०८०/८१	१३४	१०१	२३५

एच.आई.भि संक्रमित तथा प्रभावित बालबालिका (CLHIV) कावा कार्यक्रम

एच.आई.भि संक्रमित बालबालिकामा हुन सक्ने विभिन्न प्रकारका दुरव्यवहार, शोषण, भेदभाव, हिंसा र हेलचक्राईबाट संरक्षणका लागि आवश्यक वातावरण तयार गर्ने, परिवारमा माया,ममता, सम्मानपूर्ण जीवनयापन लगायत उनीहरुले शिक्षा, स्वास्थ्य, पोषण र स्याहार लगायतका आधारभुत बाल अधिकारको सुनिश्चित गर्दै उनीहरुको शारीरिक, मानशिक, भावनात्मक र संवेदनात्मक विकासमा योगदान गर्नकालागि एच.आई.भि संक्रमित बालबालिकाहरु र तिनका घरपरिवारलाई सामाजिक संरक्षण प्रदान गर्नको लागि यो कार्यविधि बनेको हो ।

सिएलटी कार्यक्रम (Community-Led Testing)

एच.आई.भि भाईरसको संक्रमण छ छैन भनि टेस्ट गर्ने कार्य हो ।

सिएलटी परिक्षण

आ.ब	महिला	पुरुष	जम्मा
२०८०/८१	३७	३४	७१

६.१० स्वास्थ्य बिमा कार्यक्रम

स्वास्थ्य बिमा कार्यक्रम स्वास्थ्य सेवा उपयोगको क्रममा हुने अनियोजित खर्चको जोखिमलाई अग्रिम व्यवस्थापन गर्दै वित्तिय संरक्षण प्रदान गर्ने अवधारणा अन्तर्गत सरकारले ल्याएको सामाजिक सुरक्षाको एक महत्वपूर्ण कार्यक्रम हो। समस्त नेपाली नागरिकलाई सर्वसुलभ रुपमा गुणस्तरिय स्वास्थ्य सेवा प्रदान गर्न र स्वास्थ्य सेवा उपभोगमा सुधार ल्याउनका लागि सामाजिक स्वास्थ्य बिमाको आधारमा सबैका लागि स्वास्थ्य सेवा सूनिश्चित गर्ने उद्धेश्यकासाथ २०७२ सालमा सामाजिक स्वास्थ्य सुरक्षाका रुपमा सुरुवात भएको यो कार्यक्रम हाल स्वास्थ्य बिमा बोर्डले संचालन गर्दै आएको छ । यस कार्यक्रमले सर्वव्यापि पहुँच (Universal Health Coverage, UHC) प्राप्ती तर्फ नेपाललाई अग्रसर बनाउँदै सन् २०३० सम्ममा दिगो विकास लक्ष्य प्राप्त गर्न महत्वपूर्ण भुमिका खेल्ने आशा लिएको छ ।

नेपालको संविधानले आधारभुत स्वास्थ्य सेवालाई निःशुल्क र सामाजिक सुरक्षाको हक प्रदान गरेको छ । बर्तमान संविकानको धारा ५१(ज) अन्तर्गत नागरिकको स्वास्थ्य बिमा सुनिश्चित गर्दै स्वास्थ्यमा नागरिकका आधारभुत आवश्यकता सम्बन्धि नीति अन्तर्गत उपचारमा पहुँचको व्यवस्था मिलाउने उल्लेख छ । गुणस्तरिय स्वास्थ्य सेवा प्रदान गर्ने नागरिको अधिकारको संरक्षण गर्न स्वास्थ्य बिमाद्वारा पूर्व भुक्तानीको माध्यमबाट बिमितको आर्थिक जोखिम न्यूनिकरण गर्न तथा स्वास्थ्य प्रदायको दक्षता र जवाफदेहिता अभिबृद्दी गरी स्वास्थ्य सेवामा आम नागरिकको सहज पहुँच सूनिश्चित गर्न स्वास्थ्य बिमा ऐन, २०७४ जारी भई सकेको छ । यस कार्यलाई थप व्यवस्थित गर्न स्वास्थ्य बिमा नियमावली, २०७५ समेत पारित हुन स्वास्थ्य बिमा कार्यक्रमका लागि एउटा महत्वपूर्ण खुट्किलो हो । यस नियमावलीले हालको सुविधाको थैलिलाई दई गुणाले बृद्धी गर्नुको साथै जेष्ठ नागरिकको लागि सरकारलेनै बिमा प्रिमियम तिरिदिने गरी छुट्टै इकाईको रुपमा बार्षिक रु.१००००००० बराबरको स्वास्थ्य बिमाको व्यवस्था गरिएको छ ।साथै सम्पूर्ण संगठित क्षेत्रलाई आम्दानिको एक प्रतिशत योगदान गर्नेगरी बिमामा आवद्ध अनिवार्य व्यवस्था गरिएको छ ।

मुख्य उद्देश्यः गुणस्तरिय स्वास्थ्य सेवाको पहुँच र उपयोगमा सुधारल्याई सामाजिक स्वास्थ्य बिमाको आधारमा सबैका लागि स्वास्थ्य सेवा सुनिश्चित गर्ने ।

विशेष उद्देश्यहरुः

- स्वास्थ्य सेवाका क्षेत्रमा पूर्व भुक्तानि र जोखिम न्यूनिकरणको अवस्था गरेर सर्वसाधारणका लागि थप वित्तिय संरक्षण प्रदान गर्ने ।
- वित्तिय साधनको समतामूलक परिचालन गर्ने ।
- स्वास्थ्य सेवा प्रवाहको क्रममा सेवाको गुणस्तर दक्षता र ,प्रभावकारिता ,जवाफदेहितामा सुधार ल्याउने ।

रणनीतिक लक्ष्यः- चेतनामूलक कार्यक्रम मार्फत समूदायका समूहरुलाई सक्रय सहभागिता गराउँदै एवम् गरिब तथा न्यून आए भएका बर्गलाई विशेष संरक्षण गर्दै, सार्वजनिक तथा निजी स्वास्थ्य सेवा प्रदायक संस्थाहरुसँग सहकार्य गर्दै स्वास्थ्य बिमा नीतिलाई क्रमसः विस्तार गरी देशव्यापि स्वास्थ्य बिमा कार्यक्रम संचालन गर्ने ।

रोल्पा जिल्लाको अवस्थाः

रोल्पा जिल्लामा स्वास्थ्य बिमा कार्यक्रम वि.सं. २०७४ साल मंसिर १ गतेबाट सेवा सुरु गरी हालसम्म दश वटै स्थानीय तहका ७२ वडामा सञ्चालनमा रहेको छ । रोल्पा जिल्लाभित्र ३ वटा सेवा प्रदायक संस्था रहेका छन भने देशभरीका सबै सरकारी अस्पतालमा पनि स्वास्थ्य बिमा सेवा उपलब्ध रहेको छ । रोल्पा जिल्लाबाट बिमित भएता पनि देशका जुनसुकै सूचिकृत अस्पतालबाट सेवा लिन सकिने छ । रोल्पा जिल्लाभित्रका विमित पनि विभिन्न जिल्लाका सेवा प्रदायकबाट सेवा लिईरहनु भएको छ । बिमितले आफुले पाएक पर्ने स्थानमा प्रथम सेवा बिन्दु राख्न पाउने व्यवस्था भएकाले रोल्पा जिल्लाका बिमित पनि पाएक पर्ने जिल्ला प्रथम सेवा बिन्दु राख्नु भएको छ ।

प्रायगरी त्रिवेणी, रुण्टिगढी गाउँपालिकाका बिमित दाङ जिल्लाका सेवा प्रदायकबाट सेवा लिनु भएको छ भने गंगादेव गाउँपालिकाका बिमितहरुले सल्यान लाई प्रथम सेवा बिन्दु राख्नु भएको छ ।

सेवा प्रदायक संस्थाहरुः

१. रोल्पा अस्पताल रोल्पा ,रेउघा ,
२. सुलिचौर प्राथमिक स्वास्थ्य केन्द्र सुलिचौर ,
३. होलेरी प्राथमिक स्वास्थ्य केन्द्रहोलेरी ,
४. देशै भरिका सम्पूर्ण सरकारी अस्पतालहरु

जिल्लामा बिमितको अवस्था र दर्ता सहयोगिहरुको विवरणः

स्थानीय तहको नाम	बिमितको संख्या	सक्रिय दर्ता सहयोगिहरुको संख्या	निस्कृय दर्ता सहयोगिहरुको संख्या
रोल्पा नगरपालिका	15189	10	0
सुनिलस्मृति गाउँपालिका	4690	7	1
सुनछहरी गाउँपालिका	1549	3	4
लुंग्री गाउँपालिका	2170	7	0
माडी गाउँपालिका	2674	3	3
परिवर्तन गाउँपालिका	4092	6	0
थवाङ गाउँपालिका	2206	3	2
गंगादेब गाउँपालिका	1942	4	1
त्रिवेणी गाउँपालिका	4755	6	1
रुण्टिगढी गाउँपालिका	3226	3	5
जम्मा	**42493**	**52**	**17**

रोल्पा जिल्लाको योगदान रकम संकलनः

हालसम्मः २९९१७५२५.००

गत आर्थिक बर्षमाः ८४५५३५०.००

यस कार्यक्रममा सहभागीहुन हुन गर्नु योगदान सम्बन्धि विवरण

यस कार्यक्रममा सहभागिहुन ५ जना वा सोभन्दा कम परिवार संख्या भएको परिवारले बार्षिक रुपमा प्रति परिवार रु.३५००.०० योगदान रकम तिर्नु पर्दछ । ५ जना भन्दा बढी परिवारमा सदस्य भए प्रति सदस्य रु. ७००.०० का दरले थप योगदान रकम तिर्नु पर्दछ । उक्त रकम बार्षिक रुपमा एकमुष्ट तिर्नु पर्दछ ।

छुट पाउने लक्षित वर्गहरुः

- अति गरिव
- HIV संक्रमित
- कुष्ठरोगी
- एमबि.टि.आर.डि.
- अति असक्त परिवार
- जेष्ठ नागरिक (७० बर्ष माथि)
- महिला स्वास्थ्य स्वयम् सेविकालाई ५० प्रतिशत छुट

सदस्यता हुने चक्र

सदस्य दर्ता	सेवा सुरु हुने मिति	सेवा समाप्त हुने मिति
बैशाखजेष्ठ र असार ,	भाद्र १ गते	अर्को बर्षको श्रावण मसान्तसम्म
श्रावण भाद्र र ,असोज	मंसिर १ गते	अर्को बर्षको कार्तिक मसान्तसम्म
कार्तिक मंसिर र पुष	फागुन १ गते	अर्को बर्षको माघ मसान्तसम्म
माघफागुन र चैत्र ,	जेष्ठ १ गते	अर्को बर्षको बैशाख मसान्तसम्म

नविकरण सम्बन्धि विवरणः-

स्वास्थ्य बिमाबाट निरन्तर सेवाका लागि हरेक बर्ष नविकरण गर्नु पर्दछ । यसकालागि सुरुमा जुन चक्रमा सदस्यता दर्ता भएको हो सोही चक्रमा नविकरण गर्नु पर्दछ ।

अनुसूचीहरु (ANNEXES)

अनुसूची १: आर्थिक बर्ष ०८०/८१ को जिल्ला स्तरीय बार्षिक समिक्षा तथा योजना तर्जुमा गोष्ठीको (२०८१ भाद्र ३० र ३१ गते) निचोड स्वरूप तयार गरि हस्ताक्षर गरिएको रोल्पा जिल्लाको समग्र जनस्वास्थ्य क्षेत्र सुधारका ३० बुँदे प्रतिबद्धताहरु:

१. स्थानीय तहको कुल बजेटको कम्तिमा १० प्रतिशत स्वास्थ्य क्षेत्रकालागि लगानी सुनिश्चितता गर्न अग्रसर हुने ।

२. स्थानीय तहमा जनस्वास्थ्य नीति तथा स्वास्थ्य क्षेत्र सुधारको रणनैतिक योजना तयार गर्ने । निजि क्षेत्रबाट प्रदान गरिएको सेवालाई नियमन गरि सेवाको विवरण स्थानीय स्वास्थ्य संस्थामा प्रतिबेदन गर्ने व्यबस्था मिलाउने ।

३. हरेक नीतिमा स्वास्थ्यको अबधारणालाई अङ्गीकार गर्दै स्थानीय तहमा बन्ने सबै नीतिमा जनस्वास्थ्यका सबाललाई सम्बोधन गर्ने तर्फ अग्रसर हुने ।

४. जनस्वास्थ्य सेवा ऐन, २०७५ तथा नियमावली, २०७७ कार्यान्वयनकालागि स्थानीय तहहरुलाई आवश्यक पर्ने ऐन तथा कार्यविधि निर्माणका लागि सहजिकरण गर्ने ।

५. बालमैत्री स्थानीय शासन कार्यान्वयन निर्देशिका, २०७८ र बाताबरण मैत्री स्थानीय शासन प्रारूप, २०७८ कार्यान्वयनकालागि अग्रसर हुने ।

६. स्वास्थ्य बीमा कार्यक्रमलाई बढावा दिई स्वास्थ्यमा गरिने व्यक्तिको लगानीलाई कम गराउने क्रियाकलाप संचालन गर्ने।

७. स्वास्थ्य सेवाको न्युनतम सेवा मापदण्ड (HP-MSS) मुल्यांकन कम्तिमा बर्षमा २ पटक अनिबार्य गर्ने र कार्ययोजना तयार गरि गुणस्तरीय सेवा प्रदान गर्न सहजिकरण गर्ने ।

८. वडा स्तरीय स्वास्थ्य संस्थामा जनस्वास्थ्यका सेवा तथा कार्यक्रमहरुलाई एकरुपतामा गराउन क्रमशःजोड दिने (जस्तै; कम्तिमा एक वडा एक सुरक्षित प्रसुती सेवा (Birthing Center), स्थानीय स्वास्थ्य संस्थामा उपलब्ध हुने सेवामा अन्य सेवा थप गर्दै लैजाने जस्तैः प्रयोगशाला, आँखा उपचार सेवा, मुख स्वास्थ्य सेवा आदि ।

९. सबै स्वास्थ्य संस्थाहरुको मापदण्ड अनुसारको भौतिक संरचना निर्माण, विकास तथा विस्तार कार्यको पहलकदमी गर्ने ।

१०. समुदाय केन्द्रित कार्यक्रम (जस्तै; खोप, गाउँघर क्लिनिक, महिला स्वास्थ्य स्वयमसेविका तथा स्वास्थ्य आमा समूह बैठक आदि) प्रभावकारी ढंगले संचालन गर्ने, साथै भौतिक संरचना, औजार उपकरण र सामाग्रीहरुको उपलब्धता सुनिश्चित गर्ने ।स्वास्थ्य संस्था संचालन तथा ब्यबस्थापन समिति र स्वास्थ्य आमा समुहलाई थप क्रियाशील गराउने ।

११. बिद्यालयमा स्वास्थ्यकर्मीहरुको उपलब्धता सुनिश्चित गरि बिद्यालय स्वास्थ्य शिक्षा र पोषण कार्यक्रमलाई प्राथामिकता दिने।

१२. स्थानीय तहको अगुवाईमा स्थापना गरिएका समुदाय केन्द्रित स्वास्थ्य संस्थाहरुको न्युनतम सेवा मापदण्ड, सेवाको विस्तार तथा गुणस्तर सम्बन्धि मापदण्ड तयार गर्ने ।

१३. सबै स्थानीय तहहरुमा स्वास्थ्यजन्य विपद प्रतिकार्यकालागि स्वास्थ्यजन्य विपद प्रतिकार्य योजना तयार गरि बिपद कोष समेत निर्माण गर्ने।

१४. स्वास्थ्य संस्थाजन्य फोहोरमैलाहरुको उचित बिसर्जन, व्यवस्थापन तथा संक्रमण रोकथाम सम्बन्धि क्षमता विकास तथा अन्य कार्यक्रमहरु संचालन गर्ने ।

१५. जिल्लामा बिद्यमान बालविवाह न्यूनिकरणका लागि जिल्लाका विषयगत निकायहरु र स्थानीयतहहरुसँग पैरवी र समन्वय गरी कार्ययोजना निर्माण गर्ने ।

१६. स्थानीय तह अन्तर्गत रहेका स्वास्थ्य संस्थाहरुको संगठन तथा व्यवस्थापन सर्वेक्षण (O & M Survey) गर्ने कार्यमा सहजिकरण गर्ने ।

१७. स्थानीय तह मातहतका स्वास्थ्य संस्थाहरुमा तथ्यांक भेरिफिकेसन, गुणस्तर सुधार लगायतका कार्यहरु नियमित गर्ने, स्थानीय तहमा संचालन हुने स्वास्थ्य संस्थाहरुको मासिक समिक्षा बैठकलाई नियमितता दिने, हरेक कार्यक्रमको सूक्ष्मयोजना तर्जुमा गरी कार्यान्वयन गर्ने ।

१८. जीबनपथमा आधारित स्वास्थ्य सेवालाई बढवा दिदै सेवाग्राहीले लिएको सेवाको निरन्तरता (Continuum of Care) सुनिश्चित गरि अनुगमन र फलोअप गर्दै जाने।

१९. स्वास्थ्य संस्थामा संचालित बालस्वास्थ्य, परिवार स्वास्थ्य, रोग नियन्त्रण तथा अन्य जनस्वास्थ्यका कार्यक्रमहरुलाई लक्ष अनुसार प्रगति उन्मुख हुने गरि थप प्रभाबकारी तथा गुणस्तरिय रुपले सम्पादन गर्ने, बढ्दो मानसिक स्वास्थ्य समस्या, आत्महत्या, नसर्ने रोग, लागु औषध दुर्व्यशनी तथा किशोर किशोरी यौन तथा प्रजनन स्वास्थ्य लगायत जनस्वास्थ्यका समस्याहरु सम्बोधनकालागि नविनतम खालका क्रियाकलाप गरि नियन्त्रण योजना गराउने । सुर्तीजन्य पदार्थ नियमन तथा नियन्त्रण गर्ने खालका कार्यक्रम अभियानकै रुपमा थालनी गर्ने ।

२०. स्थानीय तह स्वास्थ्य शाखा र तथा सबै स्वास्थ्य संस्थाहरुमा सम्पादन हुने विभिन्न कार्यक्रमहरुकोलागि बिषयगत फोकल पर्सन तोकी कार्यसम्पादन गर्ने ।

२१. सबै स्वास्थ्य संस्थाहरुमा प्रबिधिमैत्री स्वास्थ्य संस्था अभियानलाई निरन्तरता दिई समय सापेक्ष थप प्रबिधिहरु थप गर्दै जाने । साथै DHIS2, eLMIS, RMNCAH, eTB, MPDSR, Nepal Health Facility Registry, Health Workforce Management Information System लगाएतका सूचना प्रणाली आबस्यकता अनुसार अध्धाबधिक गर्दै जाने, तोकिएको समय भित्रै प्रतिबेदन हुने व्यवस्था मिलाउने ।

२२. पूर्णखोप तथा दिगोपना, पूर्ण गर्भजाँच, पूर्ण संथागत प्रसुती, पूर्ण उत्तरप्रसुती, कुपोषण रहित वडा, क्षयरोग मुक्त वडा, पूर्ण सरसफाई, बाल बिवाह न्यूनीकरण, किशोर किशोरी प्रजनन स्वास्थ्य जस्ता सेवा तथा कार्यक्रमलाई अभियानकै रुपमा थालनी गर्ने ।

२३. एच.आई.भी, क्षयरोग, कुष्ठरोग, मलेरिया लगायत अन्य किटजन्य रोगहरुको नियन्त्रण, रोकथाम र न्यूनीकरणका लागि बिशेष कार्यक्रम तय गर्ने र स्वास्थ्य संस्थाहरुमा निदानको दायरा बढाउने ।

२४. उपलब्ध सेवाको पारदर्शिता र जवाफदेहिताकालागि स्वास्थ्य संस्थाबाट उपलब्ध हुने सेवा तथा कार्यक्रम र प्रगति विवरण सहित बार्षिक सामाजिक परिक्षण कार्य गर्ने, स्वास्थ्य क्षेत्र सुधारमा सामाजिक उत्तरदायित्व र जनसहभागिता बढाउने ।

२५. स्थानीय स्तरमा खानेपानीको गुणस्तर निगरानी कार्यका साथै गुणस्तरीय पिउने पानीको सुनिश्चितताकालागि सचेतीकरण र खानेपानी सुरक्षा योजना (Water Safety Plan) लागु नभएका खानेपानी आयोजना तथा उपभोक्ता समितिलाई खानेपानी सुरक्षा योजना लागु गर्न प्रोत्साहित गर्ने।

२६. स्थानीय तहभित्र रहेका एम्बुलेन्सहरुको प्रभाबकारी नियमन गर्ने तथा राष्ट्रिय निर्देशिका बमोजिम दायरामा ल्याउने ।

२७. महिला सामुदायिक स्वास्थ्य स्वयं सेविकाहरुलाई दिईदै आएको आर्थिक सुविधामा समय सापेक्ष परिमार्जन/थप गर्न स्थानीय तहसँग पैरवी गर्ने ।

२८. स्वास्थ्य संस्थाहरुको नियमित प्रशासनिक कार्यसम्पादन सहजताकालागि स्वास्थ्य संस्था संचालन तथा ब्यबस्थापन समितिको खातामा बार्षिक रुपमा अनुदान रकमको ब्यबस्थापनमा सहजीकरण गर्ने, साथै बार्षिक लेखा परिक्षण समेत गर्दै जाने ।

२९. स्वास्थ्य संस्थाको सुशासन कायम हुने गरि आबश्यक सम्पूर्ण सुचकहरू पुरा गर्ने जस्तैः सुझाब पेटिका, नागरिक बडापत्र, निःशुल्क अत्याबश्यक औषधिको सूची, ब्यबस्थापन समितिको नामावली विवरण, महिला स्वास्थ्य स्वयम्

सेविकाहरुको नामावली विवरण, स्वास्थ्य संस्थाको कर्मचारी बिबरण, लक्ष अनुसारको प्रगति अनुगमन तालिका टाँस गर्ने आदि व्यवस्था मिलाउने ।

३०. जिल्लाभर स्वास्थ्य क्षेत्रमा कार्यरत गैह्रसरकारी संस्थाहरुले दोहोरोपन नहुने गरि जिल्ला तथा स्थानीय तहको प्राथमिकता र आबस्यकता बमोजिम नै हुने गरि कार्ययोजना बनाई सोहि बमोजिम कार्यक्रम निर्धारण गर्न पहल गर्ने ।

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संगीता मगर रोल्पा प्लस

अनुसूची-२. Top Ten Diseases (Three Years Trends)

FY 2078/79	FY 2079/80	FY 2080/81
Headache	Headache	Headache
Upper Respiratory Tract Infection (URTI) Cases	Gastritis (APD)	Fever
Gastritis (APD)	Fever	Gastritis
Falls/Injuries/Fractures	Upper Respiratory Tract Infection (URTI) Cases	Cough
Other Diseases & Injuries-Physical Disability(Disabled Person)	Presumed Non-Infectious Diarrhoea Cases	Upper Respiratory Tract Infection (URTI) Cases
ARI/Lower Respiratory Tract Infection (LRTI) Cases	Cough	Presumed Non-Infectious Diarrhoea Cases
PUO	ARI/Lower Respiratory Tract Infection (LRTI) Cases	Cut/Injuries
Water/Food Borne-Presumed Non-Infectious Diarrhoea Cases	Typhoid (Enteric Fever) Cases	Abdominal Pain
Typhoid (Enteric Fever) Cases	Backache (Musculoskeletal Pain)	Musculoskeletal Pain
ENT Infection-Rhinitis Cases	Cut injuries	Lower Respiratory Tract Infection (LRTI) Cases

अनुसूची ३. असि वर्ष माथिका जेष्ठ नागरिकहरुलाई घरमै स्वास्थ्य सेवा अन्तर्गतका सेवाग्राहिहरुको विवरण

पालिकाको नाम	८० वर्ष माथिका जेष्ठ नागरिकहरुको उपचार गरिएको संख्या			मुख्य रोगहरुको विवरण
	महिला	पुरुष	जम्मा	
सुनछहरी गा.पा.	३३२	२५२	५८४	Backache, URTI, Conjuctivitis, Weakness, Wound, Arthritis, Diarrhoea, Abdominal Pain, Asthama, Cough, Gastritis, Rhinitis, Fever, Headache, Chest Pain, Joint Pain, Knee Paint, Eye Infection, Toothache, Fever, Wound, Fever, HTN, Dizziness, Worm Infection, Bodyache, Allergy, Stomatitis, Monopleyia, Pneumonia, Leg Pain, Fungal Infection, Tonsilitis, Leg Pain, NAD, Oedema, Paralaysis, ARI, Ear Infection, Cut Injury, Abcess, Rhnintitis
थबाङ गा.पा.	१८०	१६२	३४२	
परिवर्तन गा.पा.	२८७	१४४	४३१	
गंगादेव गा.पा.	१५७	१८९	३४६	
माडी गा.पा.	१२०	१०४	२२४	
त्रिवेणी गा.पा.	९३	११५	२०८	
रोल्पा न.पा.	२८३	२११	४९४	
रुण्टीगढी गा.पा.	६८	९६	१६४	
सुनिलस्मृति गा.पा.	२०८	१८६	३९४	
लुङ्ग्री गा.पा.	२३२	१७६	४०८	
जम्मा	**१९६०**	**१६३५**	**३५९५**	

अनुसूची ४: रोल्पा जिल्लामा सञ्चालित एम्बुलेन्स सेवाको विवरण

क्र.सं.	संस्थाको नाम ठेगाना	एम्बुलेन्स नम्बर	संस्थाको सम्पर्क नम्बर	चालकको नाम	चालकको सम्पर्क नम्बर
१	रोल्पा अस्पताल, रेउघा	रा १ झ २०२	९८५७८५०२५२	कुमार वली	९८६६९३५११०
२	प्राथमिक स्वास्थ्य केन्द्र, होलेरी रुण्टिगढी	रा १ झ १२४	९८६२५२१७३६	टेक ब. वि.क.	९८४४९८३४९०
३	प्राथमिक स्वास्थ्य केन्द्र, सुनिलस्मृति	रा १ झ १३४	९८५७८२२८००	वरदान चौधरी	९८४३५३८६४४
४	स्वास्थ्य चौकी गजुल, सुनिलस्मृति ६	रा १ झ १३०	९८६९९६५८४४	सुरेन्द्र थापा	९८४८३२३३३२
५	खुग्री स्वास्थ्य चौकी, खुग्री	लु १ झ ८०९	९८४७८६२९५७	ठगेन्द्र महरा	९८६३१४०५०५
६	थबाङ आधारभुत अस्पताल	रा १ झ २२८	९८४१६१९८७३	कुसल परियार	९८१२८३५०४९
७	स्वास्थ्य चौकी तेवाङ, तेवाङ	रा १ झ १३९	९८५७८२४९१४	पूर्ण बहादुर विष्ट	९८६९६९९४०९
८	गंगादेव गाउँपालिका	रा १ झ १९८	९८४७९८४२४४	इन्द्र बहादुर वली	९८४४९७८२९७
९	माडी गाउँपालिका, घर्तिगाउँ	रा १ झ १९९	९८५१२१०७६०	मनोज ब. बाँठा	९८६७७९३३५०
१०	त्रिवेणी गाउँपालिका, नेर्पा	रा १ झ १९७	९८६८६३०८४१	धिरेन्द्र डाँगी	९८६६५०६७८१
११	लुग्री गाउँपालिका, किलाचौर	लु १ झ ६४०	९८५७८५५०२२	तिलक घर्तिमगर	९८६४४४५०९२
१२	पोवाङ स्वा.चौ., पोवाङ	लु १ झ ७८८	९८६३२८२६५५	क्षितिज पुनमगर	९८५७८५८६७७
१३	सुर्योदय सहकारी संस्था सुनिलस्मृति-३	रा १ च ६१५	९८५७८२४०६६	खडक बुढाथोकी	९८४२५१६२५१
१४	सयपत्री ऋण तथा सहकारी संस्था परिवर्तन गा.पा. वागमारा	रा १ च ९११	९८६८६११०७४	नवराज वाँठामगर	९८६६५०५१३०
१५	नेपाल रेडक्रस सोसाइटी शाखा कार्यालय रोल्पा	रा १ च १५९५	९८५७८३०७७	तिलक खड्का	९८४७६६०१५६

अनुसूची ५ : स्थानीय तह स्तरीय बार्षिक समिक्षा गोष्ठीको अवसरमा आ.व.२०८०/८१ को स्वास्थ्यका सूचकका आधारमा स्थानीय तहले मुल्यांकन गर्दा प्रथम स्थान हासिल गरेका स्वास्थ्य संस्थाहरुको विवरण

क्र.स.	स्थानीय तहको नाम	प्रथम भएको स्वास्थ्य संस्था	स्थान
१	लुङ्ग्री गा.पा.	पाङ स्वा.चौ.	प्रथम
२	त्रिवेणी गाउँपालिका	नेर्पा स्वा.चौ.	प्रथम
३	सुनछहरी गाउँपालिका	गाम स्वा.चौ.	प्रथम
४	गंगादेव गाउँपालिका	ओत स्वा.चौ.	प्रथम
५	थबाङ गाउँपालिका	थबाङ आधारभुत अस्पताल	प्रथम
६	रुण्टीगढी नगरपालिका	मसिना स्वा.चौ.	प्रथम
७	परिवर्तन गाउँपालिका	कुरेली स्वा.चौ.	प्रथम
८	सुनिलस्मृति गाउँपालिका	सुलिचौर प्रा.स्वा.के.	प्रथम
९	रोल्पा नगरपालिका	लिबाङ स्वा.चौ.	प्रथम
१०	माडी गाउँपालिका	घर्तीगाँउ स्वा.चौ.	प्रथम

अनुसूची ६ : जिल्लाका सबै स्थानीय तह स्तरीय बार्षिक समिक्षा गोष्ठीको अबसरमा आ.व.२०८०/८१ 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.	स्थानीय तहको नाम	प्रथम भएको स्वास्थ्य संस्था	प्राप्त स्कोर	स्थान
१	थबाङ गाउँपालिका	थबाङ आधारभुत अस्पताल	७३.८७%	१
२	त्रिवेणी गाउँपालिका	नेर्पा स्वा.चौ.	७३.०९%	२
३	रुण्टीगढी नगरपालिका	मसिना स्वा.चौ.	७१.९६%	३
४	सुनिलस्मृति गाउँपालिका	सुलिचौर प्रा.स्वा.के.	७१.८४%	४
५	माडी गाउँपालिका	घर्तीगाँउ स्वा.चौ.	६९.३६%	५
६	सुनछहरी गाउँपालिका	गाम स्वा.चौ.	६५.५०%	६
७	लुङ्ग्री गा.पा.	पाङ स्वा.चौ.	६५.३१%	७
८	गंगादेव गाउँपालिका	ओत स्वा.चौ.	६३.२९%	८
९	रोल्पा नगरपालिका	लिबाङ स्वा.चौ.	६०.९८%	९
१०	परिवर्तन गाउँपालिका	कुरेली स्वा.चौ.	५७.६०%	१०

अनुसूची ७: आ.व.२०८०/८१ 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	प्राप्ताङ्क	आ.व.२०८०/८१ मा प्राप्त स्थान (Rank)	गत.आ.व. २०७९/८० को स्थान
१	थबाङ गाउँपालिका	७३.२७%	१	३
२	सुनिलस्मृति गाउँपालिका	७३.००%	२	६
३	त्रिवेणी गाउँपालिका	७२.७५%	३	१
४	लुङग्री गाउँपालिका	७१.००%	४	५
५	माडीगाउँपालिका	६८.७४%	५	९
६	रुण्टीगढी गाउँपालिका	६६.१६%	६	४
७	परिवर्तन गाउँपालिका	६६.१६%	६	७
८	रोल्पा नगरपालिका	६५.८१%	७	२
९	सुनछहरी गाउँपालिका	६५.५५%	८	८
१०	गंगादेव गाउँपालिका	५६.७१%	९	१०

अनुसूची ८: पूर्ण खोप दिगोपना तथा सुनिश्चितता घोषणा समारोह कार्यक्रम २०८०/८१ मा उत्कृष्ट रुपमा सम्मानित खोप कार्यमा संलग्न स्वास्थ्यकर्मीहरुको नामावली विवरणः

स्थानीय तहको नाम	स्वास्थ्यकर्मीको नाम	पद	स्वास्थ्य संस्थाहरु
थबाङ गाँउपालिका	दिपाबुढा	अ.न.मी.	घोराबाङ आधारभुत स्वास्थ्य सेवा केन्द्र
परिवर्तन गाँउपालिका	नवराज वली	सि.अ.हे.ब.	पाछाबाङ स्वास्थ्य चौकी
माडी गाँउपालिका	कमला घर्तीमगर	अ.न.मी.	खर्सुडाँडा आधारभुत स्वास्थ्य सेवा केन्द्र
सुनछहरी गाँउपालिका	पदमा बुढा मगर	अ.न.मी.	सिउरी स्वास्थ्य चौकी
लुङग्री गाँउपालिका	रोम कुमारी विष्ट	सि.अ.हे.ब.	गुम्चाल स्वास्थ्य चौकी
सुनिलस्मृर्ती गाँउपालिका	पुष्पा पुन मगर	अ.न.मी.	तेबाङ स्वास्थ्य चौकी
रुण्टीगढी गाँउपालिका	ईश्वरी डि.सी.	अ.न.मी.	राङ्जात आधारभुत स्वास्थ्य सेवा केन्द्र
गंगादेव गाँउपालिका	चन्द्रिका जि.एम.	सि.अ.हे.ब.	ओत स्वास्थ्य चौकी
त्रिवेणीगाँउपालिका	कविता रोका	अ.न.मी.	नेर्पा स्वास्थ्य चौकी
रोल्पा न.पा.	रेखा श्रेष्ठ	सि.अ.न.मी.	लिबाङ स्वास्थ्य चौकी
रोल्पा अस्पताल	डा.रण बहादुर बोगटी	एम.डि.जि पी.	रोल्पा अस्पताल
स्वास्थ्य कार्यालय	माधव राउत	ज.स्वा.नि.	स्वास्थ्य कार्यालय, रोल्पा
	तिलसरी गुरुङ	को.चे.अ.	स्वास्थ्य कार्यालय, रोल्पा

अनुसूची ९: पूर्ण खोप दिगोपना तथा सुनिश्चितता घोषणा समारोह कार्यक्रम २०८०/८१ मा उत्कृष्ट रुपमा सम्मानित महिला सामुदायिक स्वास्थ्य स्वयम् सेविकाहरुको नामावली बिबरण

स्थानीय तहको नाम	महिला सामुदायिक स्वास्थ्य स्वयम् सेविकाहरुको नाम	स्वास्थ्य संस्थाको नाम	कै.
थबाङ गाँउपालिका	भिमरासी रोकामगर	छेर्लोबाङ आधारभुत स्वास्थ्य सेवा केन्द्र	
परिवर्तन गाँउपालिका	सुनकुमारी चन्द	केवरी स्वास्थ्य चौकी	
माडी गाँउपालिका	चन्द्र कुमारीडाँगी	तालाबाङ स्वास्थ्य चौकी	
सुनछहरी गाँउपालिका	करुणा घर्ती	गाम स्वास्थ्यचौकी	
लुङग्री गाँउपालिका	निमकला थापा	बडाचौर स्वास्थ्य चौकी	
सुनिलस्मृर्ती गाँउपालिका	दिर्घा सेन	खुङग्री स्वास्थ्य चौकी	
रुण्टीगढी गाँउपालिका	ओबी पुन	मसिना स्वास्थ्य चौकी	
गंगादेव गाँउपालिका	दिपा के.सी.	जिनाबाङ स्वास्थ्य चौकी	
त्रिवेणी गाँउपालिका	शारदा कुमारी घर्तीमगर	लिङदुङ आधारभुत स्वास्थ्य सेवा केन्द्र	
रोल्पा न.पा.	रमिता घर्ती	जेदबाङ स्वास्थ्य चौकी	

अनुसूची १०: आ.ब.२०८०/८१ को बार्षिक स्वीकृत कार्यक्रम अनुसार जिल्लाका महिला सामुदायिक स्वास्थ्य स्वयंसेविकाको सम्मानजनक विदाई

स्थानीय तहको नाम	महिला सामुदायिक स्वास्थ्य स्वयम् सेविकाहरुको नाम	स्वास्थ्य संस्थाको नाम	कैफियत
लुङग्री गाँउपालिका	चन्द्रकली गुरुङ	हार्जङ स्वास्थ्य चौकी	संघिय शसर्त अनुदान मार्फत जनही रु २०००० र प्रदेश सरकार श्रोतबाट जनही रु ५०००० का दरले र सम्मानपत्र सहित विदाई गरिएको
लुङग्री गाँउपालिका	मनकुमारी पुनमगर	हार्जङ स्वास्थ्य चौकी	
सुनछहरी गाँउपालिका	सेमकली वि.क.	पोवाङ स्वास्थ्य चौकी	
माडी गाँउपालिका	कमला घर्तीमगर	घोर्नेटी आ.स्वा.से.के.	
परिवर्तन गाँउपालिका	अमृता घर्तीमगर	राङसी स्वास्थ्य चौकी	
थबाङ गाँउपालिका	अमली पुन मगर	उवा स्वास्थ्य चौकी	

अनुसूची ११: जिल्ला द्रुत प्रतिकार्य टोलि (RRT) विवरण

सि.न.	नाम थर	पद	सम्पर्क नं.
१	विशाल सुवेदी	संयोजक	९८५७८२६७३१
२	डा. निरज घर्ती	सदस्य	९८४३२२२७४७
३	जित बहादुर डाँगी	सदस्य	९८४४९१८१८२
४	सिता कँवर	सदस्य	९८५७८४३१५७
५	रबिन्द्र प्रजापती	सदस्य	९८६५२९२१९९
६	डिल्ली बहादुर के.सी.	सदस्य	९८५७८२५७१७
७	माधव राउत	सदस्य	९८४७८२२४६६
८	अरुण भितु उपाध्याय	सदस्य	९८५८०२०१२०
९	डि.बी.घर्ती	सदस्य	९८५७८३०७७७
१०	कुल बहादुर डाँगी	सदस्य	९८४४९४८५५३
११	लक्ष्मी पौडेल	सदस्य	९८४५०८८७८७

अनुसूची १२ 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_CHHERLOBANG	YES	NO	NO	NO		
		3	CHU_THULOGAUN MIRUL	YES	NO	YES	NO		
			CHU_VITRIBAAN	NO	NO	NO	NO		
			MIRUL_HP	YES	YES	YES	YES		
		4	BHSC_GHORABANG	YES	NO	NO	YES		
			CHU_THARPU	NO	NO	NO	NO		
		5	UWA_HP	YES	NO	YES	YES		
2	Paribartan RM	1	KURELI _HP	YES	NO	YES	YES	1	7
		2	CHU_DADAGAUN_ RANGSI	NO	NO	NO	NO		
			RANGSI_HP	YES	YES	YES	YES		
		3	CHU_BAGHMARA	YES	NO	YES	YES		
			KEWARI_HP	YES	NO	YES	NO		

S. N.	Name of LLG	W. N.	Names of Health Facility	BC	IUCD Site	Implant Site	MA Site	RUSG Sites	No. of SBA
		4	PACHHABANG_HP	YES	NO	NO	YES		
		5	RANGKOT_HP	YES	YES	YES	YES		
			CHU_TRIVENIKHOLA	NO	NO	NO	NO		
		6	BHSC_NAAFE	NO	NO	NO	NO		
			CHU_OBANG	NO	NO	NO	NO		
3	Madi RM	1	CHU_PEDIKHOLA	NO	NO	NO	NO	1	4
			BHSC_OAT_GHORNETI	NO	NO	NO	NO		
		2	GHARTIGAUN_HP	YES	NO	YES	YES		
			CHU_BYANGKHOLA	NO	NO	NO	NO		
		3	TALAWANG_HP	YES	NO	YES	YES		
		4	BHSC_KHARSUDANDA	NO	NO	NO	YES		
		5	BHAWANG_HP	YES	NO	YES	YES		
			CHU_BHAWANG	NO	NO	NO	NO		
		6	KORCHABANG_HP	YES	NO	YES	NO		
4	Lungri RM	1	PANG_HP	YES	YES	YES	NO	1	7
			PANG_CHU	NO	NO	NO	NO		
			AIPE_CHU	NO	NO	NO	NO		
		2	SIRPA_HP	YES	YES	YES	YES		
			CHU_TALLO SIRPA_	NO	NO	NO	NO		
		3	BHSC_JUTUNGKHOLA	YES	NO	NO	NO		
			CHU_GOTHECHOUR	NO	NO	NO	NO		
			CHU_SIMLENI	NO	NO	NO	NO		
		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		
			CHU_GOTHIBANG	NO	NO	NO	NO		

S. N.	Name of LLG	W. N.	Names of Health Facility	BC	IUCD Site	Implant Site	MA Site	RUSG Sites	No. of SBA
			CHU_TALLOSEWAR	NO	NO	NO	NO		
			CHU_LALUBANG	NO	NO	NO	NO		
		6	GUMCHAL_HP	YES	NO	YES	YES		
			CHU_PATHEGUMCHAL	NO	NO	NO	NO		
			CHU_BERI	NO	NO	NO	NO		
		7	HARJANG_HP	YES	NO	YES	NO		
			CHU_HARJANG	NO	NO	NO	NO		
5	Gangadev RM	1	WOT_ HP	YES	YES	YES	YES	2	6
		2	CHU_GAMTHALE	NO	NO	NO	NO		
			JINAWANG_HP	YES	YES	YES	YES		
		3	BHSC_KUKURGHARE	YES	YES	NO	YES		
		4	CHU_KILTHOKE	NO	NO	NO	NO		
			PAKHAPANI_HP	YES	NO	YES	YES		
		5	BHSC_LODHCHAUR	NO	NO	NO	NO		
		6	BHSC_GORJALE	NO	NO	NO	NO		
		7	RAAK_HP	YES	NO	YES	YES		
6	Sunchhari RM	1	SERUM HP	YES	NO	NO	YES	1	7
			CHU_GHUSBANG	NO	NO	NO	NO		
			CHU_FULIWAAN	NO	NO	NO	NO		
		2	BHSC_BHITRIGAAM	NO	YES	NO	NO		
			CHU_JHELUNGKHUNG	NO	NO	NO	NO		
		3	GAAM HP	YES	YES	YES	YES		
		4	SIURI HP	YES	NO	YES	YES		
			CHU_JHINGA	NO	NO	NO	NO		
		5	POWANG_HP	YES	YES	YES	YES		
			CHU_RADUNG	NO	NO	NO	NO		
			CHU_NARBANG	NO	NO	NO	NO		
		6	FAGAM HP	YES	YES	YES	YES		

S. N.	Name of LLG	W. N.	Names of Health Facility	BC	IUCD Site	Implant Site	MA Site	RUSG Sites	No. of SBA
			CHU_DHANSI	NO	NO	NO	NO		
		7	JAILWANG HP	YES	NO	NO	YES		
7	Tribeni RM	1	KARETI_HP	YES	NO	YES	YES	2	10
		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		
8	Sunilsmriti RM	1	GHODAGAUN_HP	YES	YES	YES	YES	0	10
		2	KHUNGRI_HP	YES	YES	YES	YES		
			CHU_CHYANDHARA	NO	NO	NO	NO		
			CHU_GOGANPANI	NO	NO	NO	NO		
		3	BHSC_MIGHING	NO	NO	NO	NO		
		4	SULICHOUR_PHC	YES	YES	YES	YES		
		5	BHSC_GAJUL	NO	NO	NO	NO		
			CHU_QUALIGAUN	NO	NO	NO	NO		
		6	GAJUL_HP	YES	YES	YES	YES		
		7	TEWANG_HP	YES	YES	YES	YES		
		8	ARESH_HP	YES	YES	YES	YES		
9	Runtigadi RM	1	BHSC_RANJAT	NO	NO	NO	NO	1	11
		2	JAULIPOKHARI_HP	YES	YES	YES	YES		
		3	BHSC_JAWANG	YES	YES	YES	NO		
		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		

S. N.	Name of LLG	W. N.	Names of Health Facility	BC	IUCD Site	Implant Site	MA Site	RUSG Sites	No. of SBA
			CHU_GUNAM/PYURI	NO	NO	NO	NO		
10	Rolpa Mun.	1	BHSC_BAJBISAUNA	NO	NO	NO	NO	1	17
			UHC_HARIGATINA	NO	NO	NO	NO		
			UHC_KHEWASE	NO	NO	NO	NO		
		2	BHSC_DEURALI	NO	NO	NO	NO		
			ROLPA_HOSPITAL (GOVT)	YES	YES	YES	YES		
		3	KHUMEL_HP	YES	YES	YES	YES		
		4	LIWANG_HP	YES	NO	YES	YES		
		5	JEDBANG_HP	YES	YES	YES	YES		
			UHC_JAGATIPOKHARA	NO	NO	NO	NO		
		6	KOTGAUN_HP	YES	YES	YES	YES		
			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		
		8	JANKOT_HP	YES	YES	YES	YES		
			UHC_NAMLI	NO	NO	NO	NO		
			UHC_GAIRAKHUTI	NO	NO	NO	NO		
		9	WHAMA_HP	YES	YES	YES	NO		
			UHC_WHAMA	NO	NO	NO	NO		
		10	DHAWANG_HP	YES	YES	YES	NO		
			UHC_GAPA	NO	NO	YES	NO		
			UHC_DHANSHI	NO	NO	NO	NO		
Total		**72**	**123**	**61**	**38**	**59**	**47**	**12**	**84**

अनुसूचि-१३: स्वास्थ्य कार्यालय, रोल्पामा कार्यरत कर्मचारीहरुको विवरण

क्र.सं.	नाम थर	पद	सम्पर्क नम्बर	इमेल ठेगाना
१	विशाल सुवेदी	कार्यालय प्रमुख	९८५७८२६७३१	bisujee7@gmail.com
२	सिता कँवर	पब्लिक हेल्थ नर्सिङ निरिक्षक	९८४७९१३१५७	kaworsita@gmail.com
३	जित बहादुर डाँगी	ल्याव टेक्निसियन निरिक्षक	९८४४९१८१८२	jitbdrdangi@gmail.com
४	माधव राउत	जन स्वास्थ्य निरिक्षक	९८४७८२२४६६	Madhav2078@iom.edu
५	डिल्ली के.सी.	जन स्वास्थ्य निरिक्षक	९८५७८२५७१७	kcdb40@gmail.com
६	मोतिराज न्यौपाने	अधिकृतलेखा	९८५७८२५७३१	mr97moti@gmail.com
७	अरुण भितु उपाध्याय	अधिकृत तथ्यांक	९८५७८७७०१५	hellov2g@gmail.com
८	तिलसरी गुरुङ	कोल्डचेन असिष्टेन्ट	९८५७८६६१६७	nanugurung2076@gmail.com
९	हिरा बहादुर डाँगी	कार्यालय सहयोगी	९८६६९०६९९९	
१०	जयन्द्र थापा	हलुका सवारी चालक	९८४३१९५७०३	
११	फिरोज बुढा	कार्यालय सहयोगी	९८४६९२३८८१	
१२	शिशिर सुवेदी	कार्यालय सहयोगी	९८६९८७४५०८	

अनुसूचि-१४: रोल्पा जिल्ला स्थित सबै स्थानीय तहका स्वास्थ्य शाखामा कार्यरत कर्मचारीहरुको नामावली विवरण

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1	Rolpa Municipality	Tank Giri	9857851262	tankgiri20@gmail.com
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2	Sunilsmirty RM	Motim Aalam	9866906167	motim.alam30@gmail.com
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3	Lungri RM	Lependra Budhathoki	9857855022	lependrabc@gmail.com
		Dipa Kumari Bista	9866906167	dipabista1122@gmail.com
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5	Thawang RM	Tul Bahadur Pun	9851229573	pmtul07@gmail.com
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		Nirmal Buddha Magar	9860035404	mnirmal929@gmail.com
7	Madi RM	Ishwori Prasad Gautam	9847845434	gautamishwori4@gmail.com
		Jaya Prakash Buddha	9855046512	jayamagar25@gmail.com
8	Gangadev RM	Narahari Nath Yogi	9829584702	naraharinath76@gmail.com
9	Tribeni RM	Purna Bdr Budha Magar	9857824142	completemagar@gmail.com
		Krishna Kumari B.C.	9840366244	krishnabudha702@gmail.com
10	Runtigadi RM	Buddhijeevi Sejwal	9857850110	buddhijeevisejawal@gmail.com
		Asiya Bista	9845440393	bistaashiya@gmail.com

अनुसूचि-१५: Target Population (FY 2080/81)

Shrawan 2080 to Asar 2081																
Organization unit / Data	Population	Exp live birth	Exp pregnancies	0-11 Months	0-23 Months	12 - 23 Months	6-23 Months	6-11 Months	6-59 Months	12-59 Months	0-14 Years	Total 10-19 Years	Female 10-19 Years	Male 10-19 Years	Female population aged 15-49 years	Married Female population aged 15-49 years
ROLPA	231770	4802	5658	4712	9368	4672	6990	1942	20466	18090	72495	51797	26258	25539	67684	50634
Sunchhahari 01	2023	36	43	35	70	35	52	14	158	140	637	504	243	261	500	363
Sunchhahari 02	2138	42	49	40	80	40	60	17	181	160	691	500	236	264	520	379
Sunchhahari 03	2214	46	55	45	89	45	66	18	212	189	712	485	234	251	529	387
Sunchhahari 04	1827	37	43	36	73	36	54	15	147	128	613	419	212	207	490	367
Sunchhahari 05	3321	64	76	63	125	62	94	26	281	249	1033	759	375	384	847	621
Sunchhahari 06	2471	52	62	51	100	50	74	21	209	184	761	562	301	261	647	471
Sunchhahari 07	2968	50	59	49	98	48	73	20	211	186	823	630	309	321	734	547
Total Sunchhahari RM	16962	327	387	319	635	316	473	131	1399	1236	5270	3859	1910	1949	4267	3135
Thabang 01	1973	34	40	33	66	33	49	13	137	120	538	426	214	212	566	422
Thabang 02	2479	45	53	45	90	45	67	18	199	177	705	491	256	235	691	525
Thabang 03	2511	45	54	46	92	46	69	19	206	183	739	525	269	256	693	530
Thabang 04	1814	39	46	38	77	39	57	16	175	156	565	377	190	187	474	353
Thabang 05	1885	35	41	34	68	34	51	14	158	141	534	394	203	191	494	367
Total Thabang RM	10662	198	234	196	393	197	293	80	875	777	3081	2213	1132	1081	2918	2197
Paribartan 01	2911	62	73	62	123	62	92	25	262	231	870	582	291	291	819	620
Paribartan 02	4883	103	121	102	202	101	151	42	434	383	1525	1008	507	501	1414	1077
Paribartan03	3224	73	86	72	143	71	106	30	324	288	1017	663	331	332	980	751
Paribartan 04	4237	66	78	65	129	65	96	27	270	237	978	844	457	387	1384	1034
Paribartan 05	3897	75	88	75	150	75	112	31	330	293	1172	787	396	391	1108	853
Paribartan 06	2221	43	50	42	83	42	62	17	183	162	642	494	225	269	633	477
Total Paribartan RM	21373	422	496	418	830	416	619	172	1803	1594	6204	4378	2207	2171	6338	4812
Gangadev 01	2225	51	60	51	102	51	76	21	229	203	782	527	277	250	680	508

Shrawan 2080 to Asar 2081																
Organization unit / Data	Population	Exp live birth	Exp pregnancies	0-11 Months	0-23 Months	12 - 23 Months	6-23 Months	6-11 Months	6-59 Months	12-59 Months	0-14 Years	Total 10-19 Years	Female 10-19 Years	Male 10-19 Years	Female population aged 15-49 years	Married Female population aged 15-49 years
Gangadev 02	2883	60	71	60	121	60	90	25	280	249	930	614	307	307	820	627
Gangadev 03	3112	59	70	58	117	58	88	24	253	224	965	667	333	334	920	709
Gangadev 04	3628	90	106	88	175	87	130	36	425	380	1425	902	475	427	1003	724
Gangadev 05	3338	81	95	78	154	76	115	32	353	314	1159	824	425	399	958	697
Gangadev 06	3688	97	114	95	187	93	139	39	416	369	1345	923	479	444	1095	794
Gangadev 07	2532	64	76	63	126	63	94	26	275	243	924	602	293	309	734	551
Total Gangadev RM	21406	502	592	493	982	488	732	203	2231	1982	7530	5059	2589	2470	6210	4610
Madi 01	4565	100	118	99	196	98	146	41	439	389	1432	1018	508	510	1351	1004
Madi 02	2500	45	54	45	91	46	68	19	207	184	696	505	271	234	781	594
Madi 03	2903	60	71	60	121	60	91	25	255	225	971	666	323	343	821	624
Madi 04	2249	53	62	53	106	53	79	22	232	205	759	463	229	234	654	496
Madi 05	3445	61	72	61	123	61	92	25	279	248	962	652	309	343	942	730
Madi 06	2136	35	41	35	69	35	52	14	159	141	544	402	217	185	655	499
Total Madi RM	17798	354	418	353	706	353	528	146	1571	1392	5364	3706	1857	1849	5204	3947
Tribeni 01	2258	53	63	52	102	51	76	21	215	189	741	543	285	258	672	491
Tribeni 02	4799	99	116	97	192	95	143	40	413	365	1476	1095	562	533	1434	1067
Tribeni 03	2590	59	70	57	113	57	84	24	251	222	789	549	277	272	754	568
Tribeni 04	3968	87	102	84	167	83	124	35	359	316	1230	876	445	431	1205	901
Tribeni 05	3054	52	62	52	104	52	78	21	233	207	840	648	329	319	917	694
Tribeni 06	2081	41	49	41	82	41	61	17	180	159	653	466	242	224	609	458
Tribeni 07	4381	87	102	85	169	84	126	35	365	323	1293	1006	510	496	1298	965
Total Tribeni RM	23131	478	564	468	929	463	692	193	2016	1781	7022	5183	2650	2533	6889	5144
Rolpa 01	3491	65	76	63	125	62	93	26	258	226	1005	798	410	388	1122	840
Rolpa 02	5196	93	109	89	176	88	131	37	362	317	1444	1254	643	611	1834	1356
Rolpa 03	2615	48	56	46	91	46	68	19	189	165	754	627	297	330	846	637

Shrawan 2080 to Asar 2081																
Organization unit / Data	Population	Exp live birth	Exp pregnancies	0-11 Months	0-23 Months	12 - 23 Months	6-23 Months	6-11 Months	6-59 Months	12-59 Months	0-14 Years	Total 10-19 Years	Female 10-19 Years	Male 10-19 Years	Female population aged 15-49 years	Married Female population aged 15-49 years
Rolpa 04	5000	70	83	68	135	68	101	28	282	248	1187	1042	509	533	1564	1199
Rolpa 05	2396	58	68	56	110	55	82	23	225	197	776	564	283	281	719	532
Rolpa 06	3372	64	76	63	125	62	93	26	274	242	964	735	370	365	1056	794
Rolpa 07	2412	42	50	42	85	42	63	17	209	188	693	473	258	215	717	555
Rolpa 08	1925	36	43	36	72	36	54	15	166	147	516	312	164	148	532	416
Rolpa 09	3866	73	86	71	141	70	105	29	300	264	1080	824	425	399	1167	870
Rolpa 10	5429	108	127	107	212	106	158	44	451	398	1666	1180	554	626	1566	1194
Total Rolpa Muni	35702	657	774	641	1272	635	948	264	2716	2392	10085	7809	3913	3896	11123	8393
Runtigadhi 01	3839	86	101	85	169	84	126	35	369	326	1263	875	457	418	1093	813
Runtigadhi 02	1934	49	58	47	94	47	70	19	191	167	663	459	239	220	579	425
Runtigadhi 03	2747	64	75	61	119	59	88	25	240	210	868	663	345	318	795	573
Runtigadhi 04	2439	53	62	52	103	51	77	21	217	191	796	556	276	280	734	548
Runtigadhi 05	4251	97	114	94	187	93	139	39	398	350	1381	978	520	458	1294	960
Runtigadhi 06	4145	94	111	92	182	91	136	38	391	345	1286	874	439	435	1208	905
Runtigadhi 07	2975	61	72	59	117	58	88	24	259	229	927	670	360	310	881	656
Runtigadhi 08	2466	62	73	59	116	58	87	24	252	222	809	536	279	257	710	529
Runtigadhi 09	3375	61	72	62	125	63	94	26	270	238	1018	626	300	326	961	754
Total Runtigadhi RM	28171	627	738	611	1212	604	905	251	2587	2278	9011	6237	3215	3022	8255	6163
Sunilsmriti 01	3340	76	89	74	147	73	110	31	325	288	1163	800	427	373	1073	800
Sunilsmriti 02	3937	72	84	70	140	70	104	29	294	258	1120	871	465	406	1261	957
Sunilsmriti 03	3951	70	82	70	140	70	105	29	304	269	1148	881	441	440	1253	955
Sunilsmriti 04	4339	93	109	92	183	91	137	38	408	362	1395	924	471	453	1312	1003
Sunilsmriti 05	3256	68	81	67	134	67	100	28	277	243	1038	759	352	407	904	674
Sunilsmriti 06	2704	55	65	54	107	53	80	22	241	214	762	597	324	273	857	636
Sunilsmriti 07	4278	102	120	99	195	97	145	41	471	422	1548	1087	536	551	1183	851

Shrawan 2080 to Asar 2081																
Organization unit / Data	Population	Exp live birth	Exp pregnancies	0-11 Months	0-23 Months	12 - 23 Months	6-23 Months	6-11 Months	6-59 Months	12-59 Months	0-14 Years	Total 10-19 Years	Female 10-19 Years	Male 10-19 Years	Female population aged 15-49 years	Married Female population aged 15-49 years
Sunilsmriti 08	4537	106	125	104	206	103	154	43	457	405	1573	1055	536	519	1268	934
Total Sunilsmriti RM	30342	642	755	630	1252	624	935	261	2777	2461	9747	6974	3552	3422	9111	6810
Lungri 01	5395	118	139	116	231	115	173	48	519	461	1922	1284	652	632	1428	1057
Lungri 02	3871	93	109	91	181	90	135	38	364	318	1332	924	471	453	1138	839
Lungri 03	2998	74	87	72	141	70	105	30	319	283	1090	736	357	379	852	621
Lungri 04	3795	92	108	90	180	90	135	37	379	334	1413	936	491	445	1102	815
Lungri 05	3295	68	80	67	132	66	99	27	282	248	1062	789	414	375	958	703
Lungri 06	4348	97	114	94	186	92	139	39	390	342	1462	1088	552	536	1238	902
Lungri 07	2521	53	63	53	106	53	79	22	238	211	900	622	296	326	653	486
Total Lungri RM	26223	595	700	583	1157	576	865	241	2491	2197	9181	6379	3233	3146	7369	5423

अनुसूचि-१६: रोल्पा जिल्लामा स्वास्थ्य क्षेत्रमा कार्यरत विकास साझेदार प्रमुख वा प्रतिनिधीहरुको विवरण

क्र.सं.	नाम थर	पद	कार्यालयको नाम	सम्पर्क नम्बर	इमेल ठेगाना
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2	आशाराम चौधरी	जिल्ला व्यवस्थापक	रुडास नेपाल USAID/ARH	९८४९९६३३४५	aashu.rudas@gmail.com
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9	राधा बि.क.	अध्यक्ष	रोल्पा प्लस	९८47951772	rolpaplus.rolpa@gmail.com

Contact:
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Health Office, Rolpa

Rolpa Municipality-2, Reugha

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Website : www.horolpa.p5.gov.np