ANNUAL REPORT

EASTERN REGIONAL HEALTH DIRECTORATE

2071/2072 (2014/2015)

Government of Nepal
Ministry of Health

Eastern Regional Health Directorate
Dhankuta

Government of Nepal
Ministry of Health
DEPARTMENT OF HEALTH SERVICES

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PREFACE

It is my pleasant moment for me to know that the Eastern Regional Health Directorate (ERHD) is being published its Annual Report for fiscal year 2071/72. This imperative publication provides detailed statistical analysis of programme information against its targets and indicators. I believe that the information provided in this report will be helpful for the planners, researchers, service providers to setup potential target and intervention strategies of the health programme in future.

I found this report is very comprehensive as it covered all the major achievements of the health programme implemented in the region. In this report also includes services rendered other stakeholders, partners and private sectors improve the health status of the Nepalese Citizens. This report also analysis and present the progress of health components against target indicators in systematic manner of fiscal year 2071/72.

Moreover, I hope this report will also provide a good reference to organization and individuals in public health programme initiative to design appropriate policy and plan of action for effective communicable diseases prevention, control treatment and management in Nepal. Ministry of health has already adopted Gender and Social inclusion (GESI) in the programme and the focus is on inclusive development and it has been taken as an important development strategy.

Finally, I must like to appreciate and thank the Director of ERHD, Dr. Mahesh Prasad Khanal and his entire team for their hard work in development and publication of this annual report on time.

Dr. Pushpa Chaudhary
Director General

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Message

I am pleased to express my opinion on the Annual performance summary report published by ERHD, Dhankuta. This is a comprehensive report which covers the major activities of GoN, EDPs , I/NGOs and private institutions working in coordination with Eastern Regional Health Directorate.

I would like to express my gratitude to ERHD team, all DHO/DPHOs, hospitals directors and all health personnel including FCHVs working at various levels of health service delivery system for their hard work.

Finally, I hope that this report will be of great help in strengthening the health services in eastern region of Nepal. I also hope that it will provide valid information to all those who work for uplifting the health status of all citizens, particularly the poor and vulnerable group of the Nepalese society.

Dr. Bhim Acharya
Director
Management Division

Government of Nepal
Ministry of Health
EASTERN REGIONAL HEALTH DIRECTORATE
DHANKUTA

ACKNOWLEDGEMENT

It is my enormous pleasure to bring this annual report of fiscal year 2071/72 to disseminate the success and explore the possible remedies to address current challenges of all health programs in Eastern Development Region (EDR). In addition, this report also gives the insight of the actual progress on set targets with indicators and brings forth the concerns and limitations of the program. The data presented in this report are based on information submitted by the health institutions to the health management information system (HMIS) and other sources as well.

This report reflects the information about health care & services and activities carried out by public and private institutions. This report also highlights the trend and patterns of health services coverage and its utilization by the communities. In addition to this, it also provides information regarding targets vs achievements of the major health indicators and budget allocation and actual expenditure.

I wish to express my sincere gratitude to Honorable Minister for Health Mr.Ram Janam Chaudhary for his valuable support. I am also thankful to Secretary of Ministry of Health and Population Mr. Shanta Bahadur Shrestha for his untiring support to make program success in the region. My special appreciation and thanks goes to Dr.Puspa Chaudhary, Director General of the Department of Health Services for her regular support and guidance. I would also like to express my sincere gratitude to Director of management Division Dr. Bhim Acharya for his precious support and guidance in many aspects.

I would like to provide my sincere appreciation and thanks to NLR, NATA, BPKIHS, UNICEF, UNFPA, Plan Nepal, WHO-IPD, PSI, Action Aid, UMN, World Vision, SCF, AMDA- PHCC and SAATH SAATH Project, SUAAHARA, Karuna Foundation, IOM, FHI-360, IPAS, BNMT, NLF, Handicap International, Medical Colleges of Morang, Private Health Care facilities, Female Community Health Volunteers, Community Volunteers, Health Facility Operation and Management Committees, Individuals all external partners and Community Peoples whose efforts and contributions have made our programs successful in EDR.

Last but not the least, I would like to express my sincere appreciation to Public Health Officer Mr. Babu Ram Bhusal, TB/Leprosy Officer Mr.Dhrub Uraw, Data Entry Clerk Mr. Mahesh Kumar Yadav and entire RHD Team for their dedication and hard work for preparation and publication of this report.

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(Dr. Mahesh Prasad Khanal)
Regional Health Director
Easter Regional Health Directorate
Dhankuta

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EXECUTIVE SUMMARY

This Annual Report of Eastern Regional Health Directorate (ERHD) for the FY 2071/72 (2014/15) reflects the performances of different programs and compare with the progress made over the preceding three years.

This report was prepared by a technical team of ERHD considering all the information coming from different sources. Moreover, the report was verified by the representatives from different hospitals, DHOs/DPHOs, ERHD and supporting partners. Therefore, it is hoped that this comprehensive and analytical report will be a useful document for MoH (DoHS, DHOs, DPHOs and hospitals), health planners, researchers and academic institutions, students, supporting partners, interested organizations and individuals.

It consists of different chapters and sections. Every chapter includes background, major activities carried out in FY 2071/72, analysis of achievements, interpretation and discussion of key findings, conclusion, major issues, problems, constraints and actions to be taken.

Data used in this report were generated, compiled and verified both at periphery and district level. In addition, data are based on district level annual performance review meetings in all 16 districts and a regional level review meeting. The primary data source of this report is Health Management Information System (HMIS) which records data from 19 - government hospitals (13 District Hospitals; three other hospitals-*Lahan, Rangeli and Katari*, and three Zonal Hospitals) and one 700-bedded tertiary level medical college teaching hospital-BPKIHS, 49 Primary Health Care Centers (PHCCs) and 863 Health Posts (HPs).It also included the service coverage of 2919 Primary Health Care/Outreach Clinics (PHC/ORCs), 3807 EPI clinics and 10876 Female Community Health Volunteers (FCHVs).

In addition reports were also sought from 8 EDPs, 16 INGOs, 15 national NGOs, 40 local NGOs & CBOs and 218 Private Health Institutions-PHIs (private hospitals/nursing homes/ polyclinics & diagnostic center/health center/eye care center) working in the region. However, reports from all of such agencies were not accessible.

National Immunization Program (NIP)

The national immunization coverage of all antigens in the regular NIP program in 2071/72 has decreased compared to last fiscal years. All the antigens met the national target of > 90%. There has been 99 % coverage for BCG, 99% for Polio, 96 % for DPT-Hep B-Hib 3, 90% for Measles and 47% percent for Td-2 to pregnant women. The drop-out of DPT-Hep B-Hib1 vs DPT-Hep B-Hib3 was 4.32 and DPT-HepB-Hib 1 Vs MR was 9.9 percent in 2071/72. The vaccine wastage rate for DPT-HepB-Hib is almost same to 24 percent than the previous year which is higher than the recommended wastage rate of fifteen percent (single dose vial) and for BCG it was 76 percent, which is also higher than the recommended wastage rate of 50 percent.

Nutrition

There has been marginal decrease in growth monitoring coverage from 41 percent in 2070/71 to 40 percent in 2071/72. The percent of less than 5 years children among new growth monitored having malnourished status has increased slightly from 1.6 percent in last year to 1.9 percent this year. Two rounds of Vitamin A capsules were distributed to children aged 6 to 59 months. Eighty percent of the pregnant women received Anti-helminthic treatment, 85 percent of pregnant women received iron tablets while only 46 percent of post-partum mothers received Vitamin A.

CB-IMNCI

The total number of less than 2 months cases are in decreasing trend for the past three fiscal years, a decrease from to 13574 in 2069/70 and 12154 cases in 2070/71 and 11324 in this year. There has been a fluctuating trend in the number of cases treated for SBI, LBI, Low weight and hyperthermia over the three years period. LBI cases were reported highest which was 8132 in number and lowest cases were of hyperthermia (190) in FY 071/072. Death cases reported has been in increasing trend with a total of 27 deaths reported in FY 071/72. Feeding problems, Treatment by Gentamycin and Cotrim, referrals is in decreasing trend.

Diarrhoeal cases per 1,000 under-five populations have decreased to 481 in 2071/72 from 654 in FY 2070/71 and 614 in FY 2069/70.Percentage of diarrhoeal cases suffering from dehydration was found 35. Treatment of diarrhoea by Zinc+ Oral Rehydration Salt (ORS) has found to be 86 percent in this FY.

Safe motherhood

ANC first visit at any time has improved to 100 % in FY 2071/72 from 91% in FY 2070/71. The 4th ANC as protocol has slightly decreased to 50 % in FY 2071/72 from 52 % in FY 2070/71. However, there has been slight decrease in the gap between 4th ANC visits (50 percent) and institutional deliveries (49 percent) as compared to FY 070/71 when the gap was 6. High CS rate particularly in private hospitals was identified as a major issue despite of the fact that there was need of further strengthening institutional deliveries, fulfillment of trained human resources and proper adherence of protocol.

The delivery conducted by SBAs as percentage of expected live births was 49 percent in FY 2071/72, which was increased 3 percent compared to FY 2070/71. The institutional deliveries among expected live births increased by 5 percent in FY 2071/72(49%) compared to 44 percent in FY 2070/71.

Family Planning

The Contraceptive Prevalence Rate (CPR) of the region was 38%, which has decreased from 40 in FY 2070/71. High rate of migration of youth from districts of the region (23.3 of total absentees, CBS 2011) might be possible cause for low CPR. The common choice of spacing contraceptive method was Depo-Provera. Decreasing male participation in sterilization, quota based supply of long term spacing methods and low reporting status of the private health institutions were some key issues in family planning programme.

FCHVs Programme

Mothers' group meetings as targeted have increased to 94 percent in 2071/72 from 82 percent in FY 2070/71.However, reporting from FCHVs has decreased as compared to last FY (from 91 to 85). FCHVs were overwhelmed with multiple tasks and mandatory retirements of FCHVs as per age bar limitation were some key issues.

PHC Outreach Programme

The percentage of PHC ORCs conducted against the target was slightly decreased to 87 from 91 in FY 2071/72 as compared to last FY 2070/71. However there was low attention in quality assurance in services provided by PHC /ORCs. The reasons were insufficiency of kit boxes, lack of PHC /ORCs management committees and irregular presence of health workers. The average number of people served per PHC/ ORC per month was 19 which has slightly decreased from 22 in previous year.Lack of electoral bodies at local level to accelerate efficient management of PHC /ORC remains as a key issue.

Disease control

Tuberculosis: The case finding rate of tuberculosis has increased to 75 percent in FY 2071/72 from 74 percent in FY 2070/71. Only one district i.e Solu (96 percent) in the region has met the target of case finding as defined by WHO. Additionally, the case finding rate of for districts Bhojpur, Khotang, Okhaldhunga and Saptari in the region was 40 or below percent in FY 2071/72. The regional achievement of TB case finding for the last one decade was less than 70 percent which has slightly improved in consecutive two years. The low case finding remains one of the major issues in the region and NTC has been suggested to improve the case finding in the low performing districts. The treatment success rate has achieved the national target of 90% in the region (93 % in 2071/72).

Leprosy: There were a total of 807(408 PB and 399 MB) new leprosy cases recorded in the region at the end of FY 2069/70. Out of 807, 408 were recorded as MB and 399 were PB. Regarding the case load of new cases, 11 districts of the region have a total of 67 cases whereas majority of the cases (740) were from 5 Terai districts.

Malaria: The annual blood slide examination rate has been fluctuating over last three consecutive years. It was 0.86 % and 0.73 % in FY 2070/71 and 2071/72 respectively. The % of PF cases among total cases dropped to 0.01% in FY 2071/72 from 0.81 % in FY 2070/71 in the region.

Kala-azar: The Kala-azar cases were reported mainly from Terai districts of the region. Jhapa, Saptari, Siraha, Sunsari, Morang and Udayapur are highly affected districts in the region. The incidence rate of Kala-azar/10,000 risk population has decreased to 0.09 in FY 2071/72 from 0.58 in previous year. There was two reported death due to Kala-azar one each from Jhapa and Udayapur in the region in FY 2071/72.

HIV/AIDs & STDs: A total of 229 cases as compared to 286 (FY 2070/71) were reported this year among the total tested of 23125 (19564 tested in FY 2071/72). Morang (131) reported highest number of cases followed by Jhapa (104) and sunsari (98) . The issue of the region was partial reporting from private/NGOs run HIV counseling & testing centers.

Curative services : A total of 38, 91,532 outpatients' new visits were reported in 2071/72 in eastern region. The regional trend of outpatients' new visits as % of total population has decreased by 1 percent compared to FY 2070/71.

Supporting program

Health Training: Training was delivered through the network of Regional Health Training Centre, district level training facilities in 16 districts and 2 Training Health Posts (Jhorard and letang). RHTC provided training on CoFP Counseling, GESI, AHW and Sr.AHW Training, Emergency in RH (TOT), FCTC, ASRH, Non Health professional orientation with 100% target vs achievement for FY 2071/72.

Health Education, Information and Communication: The health education and communication units in the district health offices implemented IEC activities utilizing various media and methods according to the needs of the local people in the district. Local media and languages were used in the district for dissemination of health messages. The main activities included health education programs in the schools and community; printed materials production and distribution; production and dissemination of regular, weekly and periodic radio programs; publication and dissemination of health messages through newspapers, social mobilization, advocacy, workshop/seminar, folk events, observation on special days and exhibitions. At

regional level radio programs were aired and orientations for journalists and stakeholders on public health issues were conducted.

Logistic supply: Regional medical store and district store were responsible for timely supply of drugs, equipment, contraceptives, vaccine and other commodities to the service outlets including storage and maintenance of inventory. The main functions of regional medical store included repacking of drugs & other goods, supply of drugs & other goods, repair & maintenance of vehicle, cold chain equipment & others, store supervision and medical store maintenance & construction.

Public Health Laboratory service: The goal is to provide quality health laboratory service which is accessible to every citizen at affordable cost. At present there are 3 zonal hospital based laboratories, 13 district hospital based laboratories, 3 other government hospital laboratories and 49 PHCC based laboratories. In addition, one tertiary level laboratory is in BPKIHS. The main activities included regular investigation of different lab services and lab test for emergency of influenza, encephalitis and dengue fever. A total of 41, 08, 566 laboratory services were provided from the different health institutions of the region in FY 2071/72.

Primary Health Care Revitalization: Primary Health Care Revitalization Division (PHCRD) works towards reducing poverty by providing equal opportunity for all to receive quality and affordable health care services. The major activities carried out during FY 2071/72 were free health services to marginalized population and areas. Free Health Camp (General Health Services) was conducted in Morang and Siraha districts. A total 13,627 of Ultra poor people received free OPD, health services from the hospitals across the region. Further, 624 FCHVs and 1250 Helpless/Destitute had received different hospital services at free of cost from hospital during the same period.

Personnel administration: Regional Health Directorate is responsible for the effective management of the entire health programme by mobilizing the extensive network of health workers of the region. Altogether 74 percent (3986) posts were fulfilled out of 6145 sanctioned posts. Generally, mountain and hill districts were higher percentage of vacant posts compared to Terai. There is still a need of improving personnel record keeping and defining employee's roles and responsibilities.

Financial Management: Of the total released budget Rs.1,06,38,23,000.00 ,85.00 percent Rs.90,93,66,000.00 was expensed in the eastern region during FY 2071/72. Budget expenditure rate in most of the districts was above 80 percent except Dhankuta. However, irregularities (*Beruju*) clearance still remained poor for many districts. Lack of information about district program and budget and linkages between district and regional finance team remained as major issue which is important for program planning and supervision.

HEALTH SERVICES COVERAGE FACT SHEET

Fiscal Year 2069/070 to 2071/072 (2012/2013 - 2014/2015)

Indicators		2069/70	2070/71	2071/72
1. REPORTING STATUS (%)				
1.1	District	100	100	100
1.2	Hospital	89	93	94
1.3	Primary Health Centre	102	100	100
1.4	Health Post	100	100	100
1.5	PHC-ORC Clinics	90	91	88
1.6	EPI Clinic	96	94	94
1.7	Female Community Health Volunteers	98	91	85
1.8	Non-Governmental Organizations	98	76	77
1.9	Private Health Institutions	63	75	75
2. IMMUNIZATION COVERAGE (%)				
2.1	BCG	98	107	99
2.2	DPT-Hep B-Hib 3	93	108	96
2.3	Polio	93	100	96
2.4	Measles	89	98	90
2.5	TT-2 and TT2+	82	86	79 Td
3. NUTRITION				
3.1	Growth monitoring coverage as percentage of <5 children new visits	40	41	40
3.2	Proportion of underweight (Weight/Age) children among new visits	2.21	1.6	1.9
3.3	Percentage of pregnant women receiving iron tablets	80	86	85
3.4	Percentage of postpartum mothers receiving Vitamin A	64	59	46
3.5	Percentage of pregnant women receiving anthelmintic tablets	77	81	80
3.6	Iron Tablet Compliance	44	48	46
4. ACUTE RESPIRATORY INFECTION (ARI)				
4.1	Reported incidence of ARI per 1,000 <5 children new visits	1117	1157	884
4.2	Percentage of pneumonia (mild + severe) among new ARI cases	30	29	29
4.3	Proportion of severe pneumonia among new ARI cases	0.3	0.3	0.3
5. DIARRHOEAL DISEASES				
5.1	Incidence of diarrhea/1,000 <5 children new cases	614	654	481
5.2	Percentage of severe dehydration among total new cases	0.2	0.2	0.2
6. SAFE MOTHERHOOD (%)				
6.1	Antenatal first visits(at any time) as percentage of expected pregnancy	91	92	100
6.2	Antenatal fourth visits as per protocol	53	57	50
6.3	Delivery conducted by SBA as percentage of expected live births	47	46	49
6.4	Delivery conducted by other than SBA as percentage of expected live births	4.5	6	4
6.5	Institutional delivery as percentage of expected live births	45	44	49

Indicators		2069/70	2070/71	2071/72
6.6	PNC first visit as percentage of expected live births	58	60	50
7. FAMILY PLANNING (%)				
7.1	Contraceptives Prevalence Rate (CPR)	51	40	38
7.2	Pills current users (as percentage of MWRA)	4.5	4.3	3.8
7.3	Depo-Provera current users (as percentage of MWRA)	10.7	10.2	9.2
7.4	IUCD current users (as percentage of MWRA)	1.98	2.02	2.21
7.5	Implant current users (as percentage of MWRA)	1.84	1.89	2
7.6	Sterilization current users (as percentage of MWRA)	15.8	19.49	18.31
7.7	New Acceptors total spacing method (as percentage of MWRA)	11.9	10.21	10.32
7.8	New Acceptors Method Mix as percentage of MWRA	10.3	10.8	10.8
8. TUBERCULOSIS (%)				
8.1	Case detection rate	67	74	75
8.2	Cure rate	92	92	93
8.3	Success rate	92	92	91
8.4	Sputum conversion rate	90	89	93
8.5	Slide positivity rate	7.3	8.5	6.4
8.6	Overall agreement rate	98	98	98
9. LEPROSY (%)				
9.1	New Case Detection Rate (NCDR)/10,000 population	1.4	14.06 per 100,000	1.3
9.2	Disability grade II among new cases	3.5	4.3	3.9
9.3	Prevalence Rate (PR)/10,000 population	0.9	0.93	0.96
10.Malaria				
10.1	Annual Blood Slide Examination Rate (ABER)/100 risk population	0.7	0.9	0.73
10.2	Annual Parasite Incidence (API) per 1,000 risk population	0.06	0.07	0.07
10.3	Proportion of P. Falciparum	1.05	0.81	0.01
10.4	Incidence of Kala-azar/10,000 risk population	0.32	0.58	0.09
11.OPD services				
11.1	Total OPD visits as percentage of total population	82	77	76
11.2	Proportion of OPD visits by sex(Female)	55	55	56
11.3	Number of people using free health services in hospitals' OPD			
	Ultra poor/poor	34292	26915	13627
	Disable	497	2381	922
	Senior citizen	10456	17116	31113
	FCHVs	638	1106	624

ACRONYMS

ABER	Annual Blood Examination Rate
AES	Acute Encephalitic Syndrome
AFP	Acute Flaccid Paralysis
AHW	Auxiliary Health Worker
AI	Avian Influenza
AIDS	Acquired Immune Deficiency Syndrome
AMTSL	Active Management of Third Stage of Labour
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
APD	Acute Peptic Disease
API	Annual Parasite Incidence
ARI	Acute Respiratory Infection
ART	Anti-Retroviral Therapy
ASBA	Advance Skilled Birth Attendant
BCC	Behavior Change Communication
BCG	Bacillus Chalmette and Guerin
BCS	Balanced Counseling Strategy
BEOC	Basic Emergency Obstetric Care
BPKIHS	Bisheshor Prasad Koirala Institute of Health Science
C/S	Caesarean Section
CA/CO	Computer Assistant/Computer Officer
CAC	Comprehensive Abortion Care
CARE	Co-operative For Assistance & Relief Everywhere
CBIMNCI	Community Based Integrated Management of Childhood and Neonatal Illness
CBNCP	Community Based Neonatal Care Programme
CBO	Community Based Organization
CBR	Community Based Rehabilitation
CBS	Central Bureau of Statistics
CDD	Control of Diarrhoeal Diseases
CDP	Community Drug Programme
CEOC	Comprehensive Emergency Obstetric Care
CFR	Case Fatality Rate
CHD	Child Health Division
CHW	Community Health Worker
CIAA	Commission for Investigation of Abuse of Authority
CLT	Comprehensive Leprosy Training
CMI	Clinical Malaria Incidence
CoFP	Comprehensive Family Planning
COPD	Chronic Obstructive Pulmonary Disease
CPR	Contraceptive Prevalence Rate
CRS	Contraceptive Retail Sales
CSD	Clinic Support Day
CTS	Clinical Training Skills
CYP	Couple Years Protection
DACC	District AIDS Coordination Committee
DDA	Department of Drugs Administration
DDC	District Development Committee
DHMC	District Health Management Committee
DHMGN	District Health Mothers Group Network

DHO	District Health Office
DoHS	Department of Health Services
DOTS	Directly Observed Treatment Short Course
DPHO	District Public Health Office
DPT	Diphtheria, Pertussis and Tetanus
DQSA	Data Quality Self-Assessment
DR	Drug Resistant
DTLA	District Tuberculosis and Leprosy Assistant
DTOT	District Training of Trainers
ERMS	Eastern Regional Medical Store
EDCD	Epidemiology and Disease Control Division
EDPs	External Development Partners
EDPT	Early Diagnosis and Prompt Treatment
EHCS	Essential Health Care Services
ENT	Ear Nose Throat
EOC	Emergency Obstetric Care
EPI	Expanded Programme on Immunization
ERHD	Eastern Regional Health Directorate
FCHV	Female Community Health Volunteer
FHD	Family Health Division
FM	Frequency Modulation
FP	Family Planning
FPAN	Family Planning Association of Nepal
FSWs	Female Sex Workers
FY	Fiscal Year
GBV	Gender Based Violence
GDP	Gross Domestic Product
GEM	Global Empowerment Measure
GESI	Gender Equality and Social Inclusion
GM	Growth Monitoring
GoN	Government of Nepal
HA	Health Assistant
HDB	Hospital Development Board
HDI	Human Development Index
HE	Health Education
HepB	Hepatitis B
HFOMC	Health Facility Operation Management Committee
HFs	Health Facilities
HI	Health Institution
Hib	Haemophilus Influenza B
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HP	Health Post
HRDC	Hospital Based Rehabilitation and Development Center
HRH	Human Resources for Health
HSR	Health Sector Reform
HSSP	Health Sector Support Programme
HWs	Health Workers
ICU	Intensive Care Unit
IDD	Iodine Deficiency Disorder
IDU	Injection Drug User

IEC	Information, Education and Communication
IMR	Infant Mortality rate
INF	International Nepal Fellowship
INGO	International Non-Governmental Organization
IP	Infection Prevention
IPD	Immunization Preventable Diseases
IPC	Interpersonal Communication
IUCD	Intra Uterine Contraceptive Device
IYCF	Infant & Young Child Feeding
JE	Japanese Encephalitis
Km	Kilometer
Lab. Asst.	Laboratory Assistant
LBI	Local Bacterial Infection
LCD	Leprosy Control Division
LDC	Least Developed Countries
LEC	Leprosy Elimination Campaign
LMD	Logistic Management Division
LMIS	Logistic Management Information System
LWF	Lutheran World Federation
M&E	Monitoring and Evaluation
MA	Medical Abortion
MARP	Most At Risk Population
MB	Multi-Bacilli
MCH	Maternal and Child Health
MCHW	Maternal and Child Health Worker
MCs	Microscopy Centers
MD	Management Division
MDA	Mass Drug Administration
MDG	Millennium Development Goals
MDT	Multi Drug Therapy
MMR	Maternal Mortality Ratio
MNH	Maternal Neonatal Health
MNT	Maternal Neonatal Tetanus
MO	Medical Officer
MoH	Ministry of Health
MoLD	Ministry of Local Development
MRA/MRO	Medical Record Assistant/Medical Record Officer
MWRA	Married Women of Reproductive Age
NACC	National AIDS Co-ordination Committee
NCASC	National Center of AIDS and STD Control
NDHS	Nepal Demographic Health Survey
NFCC	Nepal Fertility Care Center
NGOs	Non-Governmental Organizations
NHEICC	National Health Education Information and Communication Center
NHSP	Nepal Health Sector Support Program
NHTC	National Health Training Center
NID	National Immunization Day
NIP	National Immunization Programme
NLR	Netherlands Leprosy Relief
NLSS	Nepal Living Standard Survey
NMR	Neonatal Mortality Rate

NRCS	Nepal Red Cross Society
NSMP	Nepal Safer Motherhood Project
NT	Neonatal Tetanus
NTC	National Tuberculosis Center
ODA	Official Development Assistance
OPD	Out Patient Department
OPV	Oral Polio Vaccine
ORC	Outreach Clinic
ORS	Oral Rehydration Solution, Oral Rehydration Salts
ORT	Oral Rehydration Treatment
OT	Operation Theater
PAC	Post Abortion Care
PB	Pauci-Bacilli
PEM	Protein-Energy Malnutrition
PF	Plasmodium Falciparum
PHC	Primary Health Care
PHCC	Primary Health Care Centre
PHC-ORC/PHC/ORC	Primary Health Care-Outreach Clinic
PHCRD	Primary Health Care Revitalization Division
PHN	Public Health Nurse
PHO/PHA	Public Health Officer/Public Health Administrator
PME	Planning, Monitoring and Evaluation
PMTCT	Prevention of Mother to Child Transmission
PNC	Post Natal Care
PO	Planning Officer
POID	Prevention of Impairment and Disability
PPIUCD	Post-Partum Intra Uterine Contraceptive Device
PR	Prevalence Rate/ Principal Recipient
PSBI	Possible Severe Bacterial Infection
PV	Plasmodium Vivax
QA	Quality Assurance
RDT	Rapid Diagnostic Test
RED	Reaching Every District
RH	Reproductive Health
RHCC	Regional Health Co-ordination Committee
RHCT	Regional Health Co-ordination Team
RHD	Regional Health Directorate
RHTC	Regional Health Training Center
SA/SO	Statistical Assistant/Statistical Officer
SBA	Skilled Birth Attendant
SCF	Save the Children Fund
SDC	Swiss Development Cooperation
SDIP	Safe Motherhood Delivery Incentive Programme
SHP	Sub Health Post
SLTHP	Second Long-Term Health Plan
SM	Safe Motherhood
SMNHLTP	Safe Motherhood and Neonatal Health Long Term Plan
SN	Staff Nurse
SPR	Slide Positivity Rate
Sq	Square
SRH	Sexual and Reproductive Health

STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infection
SWC	Social Welfare Council
TB	Tuberculosis
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
TNA	Training Need Assessment
TO	Training Officer
TOT	Training of Trainers
TT	Tetanus Toxoid
UMN	United Mission to Nepal
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
USI	Universal Salt Iodization
VACC	Village AIDS CO-ordination Committee
VAD	Vitamin A Deficiency
VBD	Vector Borne Diseases
VCA	Vector Control Assistant
VCT	Voluntary Counseling and Testing
VDC	Village Development Committee
VHW	Village Health Worker
VPD	Vaccine Preventable Diseases
VSC	Voluntary Surgical Contraceptive
WHO	World Health Organization
WRA	Women of Reproductive Age

1. INTRODUCTION

1.1 Background

The Annual Report analyses the performance and achievements of Eastern Regional Health Directorate (ERHD) for the Fiscal Year (FY) 2071/72 (2014/2015). It mainly deals with the program introduction (background, specific policies, goal, and objectives), major activities and analysis of achievement, identification of major issues and actions to be taken in order to improve performance. In addition, this report also provides information on contributions from partners.

Preparation of this report followed the District Annual Performance Review Meetings conducted in all sixteen districts which concluded in the Regional Annual Performance Review Meeting. Regional annual performance review meeting was organized between 10-12 Magh 2072 BS (24-26 January , 2016) at Biratnagar for the FY 2071/72.

During the workshop, the data generated from the HMIS in the form of raw numbers were carefully and critically analyzed utilizing the selected indicators along with data available from other sources. These data were interpreted during the presentations and discussions and key issues were identified and presented in the meeting.

The review meeting was inaugurated by Mr. Mahendra Bahadur Gurung, Regional Administrator. Dr. Puspa Chaudhary, Director General, Department of Health Services also attended the review meeting and addressed the key issues in addition to other directives and updates. There was participation of Chief of District (Public) Health Offices, Public Health Officers or Statistical Officers/Assistants from all districts, Medical superintendents or representatives from zonal hospitals, directors from Divisions of DoHS and Centres, officials from Ministry of Health (MoH) and representatives from External Development Partners (EDPs). The participants from different sectors contributed to make the review meeting quite participatory and interactive. During the review meeting, the regular health program & activities of the region for the FY 2071/72 were thoroughly reviewed with the following objectives:

- To review health programs and activities carried out in FY 2071/72
- To review response to recommendations made by the FY 2071/72 Annual Regional Review Workshop
- To analyze service coverage
- To identify management issues relating to problems/constraints and obtain suggestions and action plan to address those issues
- To recommend specific programs/strategies especially for low performing districts to boost up the service coverage
- To share best practices performed by districts

In brief, the report is presented in different program-wise sections. Each program is structured in line with program background, major activities carried out in FY 2071/72, analysis of achievements and program issues and action to be taken. The verified raw and analyzed data including target population of the region for FY 2071/72 are available in the annexes of this report.

1.2 Eastern Region at a Glance

Geography/Bio-physical condition

Eastern region is one of five development regions located at the eastern part of the Nepal with headquarters at Dhankuta. It comprises three administrative zones (Mechi, Koshi and Sagarmatha), 16 districts (3 mountainous, 8 hilly and 5 terai/plain), 967 Village Development Committees (VDCs), 3 Sub-metropolitan city and 60 Municipalities.

The region is classified into three ecological regions with extreme variations in natural environment ranging from tropical plain to alpine heights with decreasing elevations from north (8,848 meters at Mt. Everest in Solukhumbu, the highest mountain in the world) to south (60 meters at Kechana Kalan in Jhapa district, Nepal's lowest point).

The region has many castes/ethnicities and languages. The major castes/ethnic groups consist of Chhetri, Brahman, Rai, Limbu, Yadab, Tharu, different Madhesi groups and Dalit. Major languages are Nepali, Maithili, Limbu, Tharu, Tamang, Urdu and other indigenous languages. Major religions include Hinduism, Buddhism, Islam, Kirat and Christianity (Census 2011).

The major agro-products of the region are paddy, maize, sugarcane, wheat, barley, millet, potato, tobacco, oil seed, vegetables, tea, cardamom and ginger. Around 550 large and medium companies are running in the following areas: agriculture and forestry, manufacturing, mining and quarrying, electrical, vegetable oil and garments. The major cities consists of Biratnagar, Dharan, Dhankuta, Itahari, Rajbiraj, Birtamod, Damak, Gaighat, Lahan, Ilam and Namche Bazaar, the town near the base camp of Mt. Everest.

Table 1: Eastern Region at a Glance

Total Area	28,456 Sq Km	
Population Density	205 per Sq Km	(Census , 2011)
Total Population	58, 11, 555 (21.9% of total population)	
Male	27, 90, 483 (48%)	
Female	30, 21, 072 (52%)	
Sex Ratio (Males/100 Females)	92.4	
Population Growth Rate	0.88	
Average Household Size	4.72	
Total Households	12,31,505	
Absent Population	4,29,870 (22.3% of total absentees)	
GDP Per Capita (PPP US$)	2,260	(UNDP, 2013)
Life Expectancy at Birth	66.16	CBS 2001
Under 5 Child Mortality Rate	55/1,000 live births	(MoHP, New
Infant Mortality Rate	47/1,000 live births	ERA, and ICF
Neonatal (<28 days) Mortality Rate	30/1,000 live births	International Inc., 2012).
Human Development Index	0.526	(UNDP, 2009)
Human Poverty Index	33.7	
Literacy Rate	67.1% (M-76%, F-59%)	Census 2011
Female Household Heads	24.4%	NLSS, 2011

Demographic Situation

According to target population for 2071/72 provided by HMIS section, the region has a total of 60,10, 650 population with a population growth rate 0.88 and average household size 4.72 (Census, 2011). Out of which under one year population is 1,29,774, 12-59 months population is 4,74,322, under 5 population is 6,04,096, female population (15-49 years) is 17,17,631, expected pregnancy is 1,54,634 and adolescent population (10-19 years) is 13,72,739 and expected live birth is 1,31,133. For more detail refer to annex-1.

Socio-economic situation

The Human Development Index (HDI) of this region was 0.526. The Global Empowerment Measure (GEM) varies from 0.483 in the Eastern Terai to a high of 0.538 in the Eastern Mountains. The Human Poverty Index (HPI) value for this region as a whole was estimated at 33.7 but it was higher in the Mountains (37.6) and lower in the Terai (33.8) (UNDP, 2009)**.**

The literacy rate of the population 5 years and older in this region was 67.1 percent in which 59 percent were female and 76 percent were male (Census, 2011). Due to stagnation in the overall economy, political transition and power (electricity) cut off, local employment opportunities have declined in recent years however agriculture still provides employment to the majority of self- employed people in the region. Migration from five Terai districts in the region is high which send the highest number of migrant workers abroad for foreign employment.

61% of the households have toilet which is slightly higher than the national average of 60%. In Tarai only 53% of the households have toilets relative to 72% in hill and 75% in mountain in this region (CBS 2011).

Health Service Delivery System

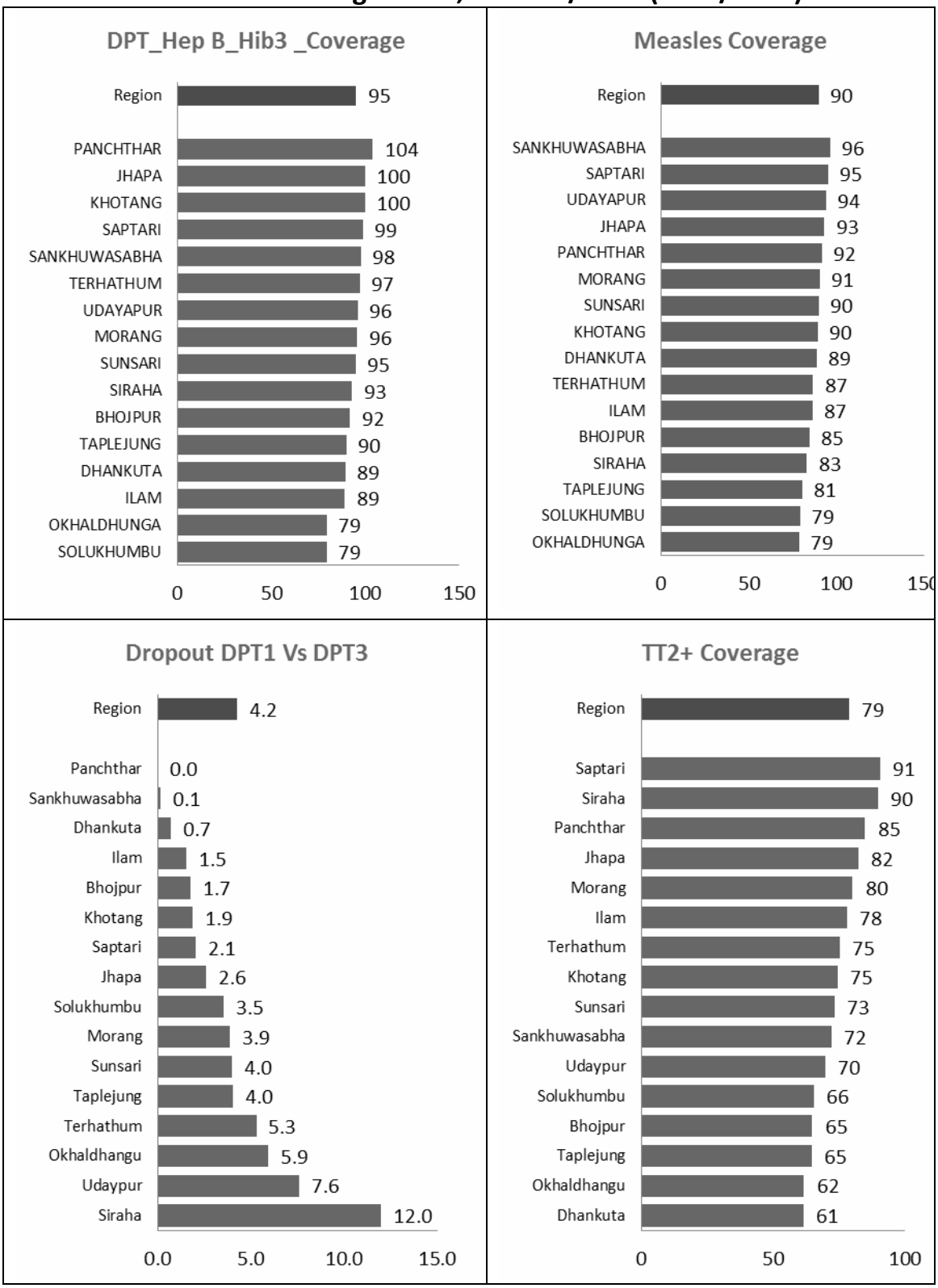
Basic primary health services are provided by 863 health posts, 49 primary health care centers, 19 – District level government hospitals (13 district hospitals, 3 other hospitals- Lahan, Rangeli, Katari Hospital and 3 zonal hospitals) and one 700-bedded tertiary level teaching hospital (BPKIHS). There are a total of 10876 FCHVs in the region along with 2919 PHC-ORCs and 3807 EPI clinics.

Saptari, Morang, Jhapa have District Public Health Office and Zonal Hospital. Similarly, Ilam districts have District Public Health Office. The rest of the districts have a district health office and district hospital, responsible for performing all assigned public health activities in the district and delivery of basic health services. According to the updated Human Resource Profile, 26 percent of the sanctioned posts are vacant in the region.

There are 218 registered private hospitals/nursing homes/ polyclinics & diagnostic centres/health centres/eye care centres, 265 ambulances and 54 Ayurvedic ausadhalaya provide health care services in the region. Moreover, 8 EDPs, 16 INGOs, 15 national NGOs and 40 local NGOs & CBOs are working in the region.

2. CHILD HEALTH PROGRAMME

National Immunization Programme, FY 2071/2072 (2014/2015)



2.1 NATIONAL IMMUNIZATION PROGRAM

2.1.1 Background

The National Immunization Program (NIP) is a high priority program (P1) of Government of Nepal. Immunization is considered as one of the most cost-effective health interventions. NIP has helped in reducing the burden of Vaccine Preventable Diseases-VPDs (TB, diphtheria-pertussis-tetanus-hepatitis B and haemophilus influenza, poliomyelitis & JE) and child mortality. NIP has contributed towards achieving the MDG4 (DoHS, 2012). Although there is increasing ownership and participation of community, few children are still deprived of receiving immunization services in certain areas.

The objectives of the NIP are as follows:

Objective 1: Achieve and maintain at least 90% vaccination coverage for all antigens at national and district level by 2016

Objective 2: Ensure access to vaccines of assured quality and with appropriate waste management

Objective 3: Achieve and maintain polio free status

Objective 4: Maintain maternal and neonatal tetanus elimination status

Objective 5: Initiate measles elimination

Objective 6: Accelerate control of vaccine-preventable diseases through introduction of new and Under used vaccines

Objective 7: Strengthen and expand VPD surveillance

Objective 8: Continue to expand immunization beyond infancy

2.1.2 Major Activities

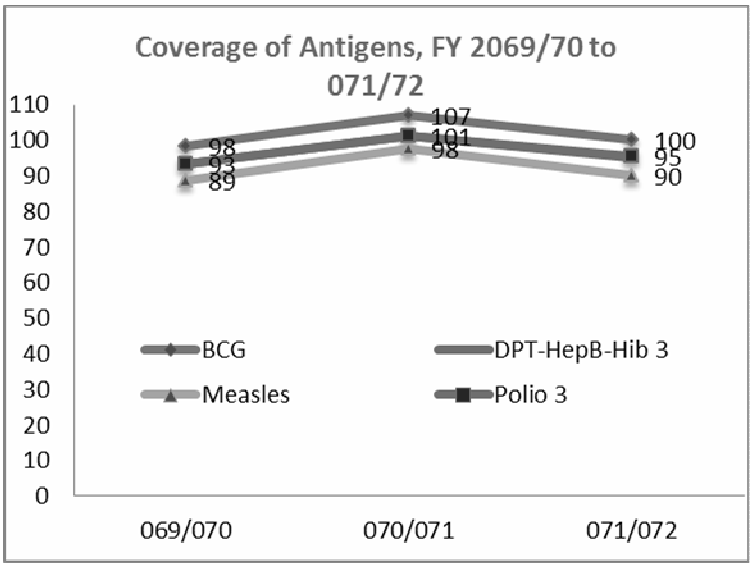
The planned sets of activities were more or less identical in all districts. The following were the major activities carried out during FY 2071/71:

- Provision of routine immunization services delivery either through fixed sites or outreach sessions: 3-5 session/month/VDC as per micro plan, conducted Reaching Every District (RED) micro planning in districts
- Celebrated "Immunization Month" and “National Immunization Day”
- Training provided to all health workers in the region
- DQSA was done in Panchthar, Bhojpur, Khotang, Terhathum, Siraha and Morang districts.
- Repair of cold chain instruments
- Recruitment of Vaccinators
- Vaccine and supplies (Icepacks, syringes, vaccine carriers& safety boxes) Transportation
- National polio campaign
- JE vaccination campaigns were undertaken in JE affected districts of the region
- Supervision: conducted joint supervision and monitoring in poor performing districts
- Conducted review of immunization services as an integrated child health at VDC level
- Continued school Td immunization program in selected districts
- Continued integrated VPDs surveillance (AFP, Measles, NT, AES, pneumonia for AI and Hib), measles case-based surveillance expanded, outbreaks of suspected measles investigated and responded followed by lab confirmation

2.1.3 Analysis of Achievement

Routine Immunization

Figure 1: Coverage of Antigens, FY 2069/70 to 071/72



As shown in Figure 1, the coverage of all antigens in the region has fluctuated and decreased this year. Since the coverage is decreased than past year, all the achievement is more than 90% there by clearly met the national target of >90%.

Table 2: Immunization Coverage, by Districts, FY 2069/070 to 071/072

Districts	BCG coverage			DPT-HepB-Hib 3 coverage			Measles Coverage			TT2 & TT 2+(Td) coverage (Pregnant women)		
	069/070	070/071	071/072	069/070	070/071	071/072	069/070	070/071	071/072	069/070	070/071	071/072
TAPLEJUNG	89	102	90	92	101	90	88	95	81	71	81	65
PANCHTHAR	101	104	97	101	108	104	98	106	92	85	91	85
ILAM	85	88	90	82	90	89	81	90	87	80	86	78
JHAPA	93	110	101	90	104	100	84	100	93	87	97	82
MORANG	100	123	107	90	105	96	85	97	91	70	80	80
SUNSARI	96	100	95	89	97	95	85	94	90	82	70	73
DHANKUTA	91	101	90	91	101	89	89	99	89	70	79	61
TERHATHUM	94	101	95	95	102	97	85	97	87	73	90	75
S.SABHA	97	101	98	96	99	98	91	97	96	82	87	72
BHOJPUR	90	93	92	89	94	92	83	93	85	62	68	65
SOLUU	86	85	80	86	85	79	78	84	79	90	87	66
O.DHUNGA	93	91	82	90	89	79	80	86	79	62	65	62
KHOTANG	109	103	93	106	102	100	99	103	90	86	87	75
UDAYAPUR	100	104	102	94	102	96	92	94	94	79	72	70
SAPTARI	101	106	101	99	105	99	97	104	95	94	100	91
SIRAHA	114	115	116	105	105	93	100	101	83	103	98	90
Region	98	107	100	93	101	95	89	98	90	82	86	79

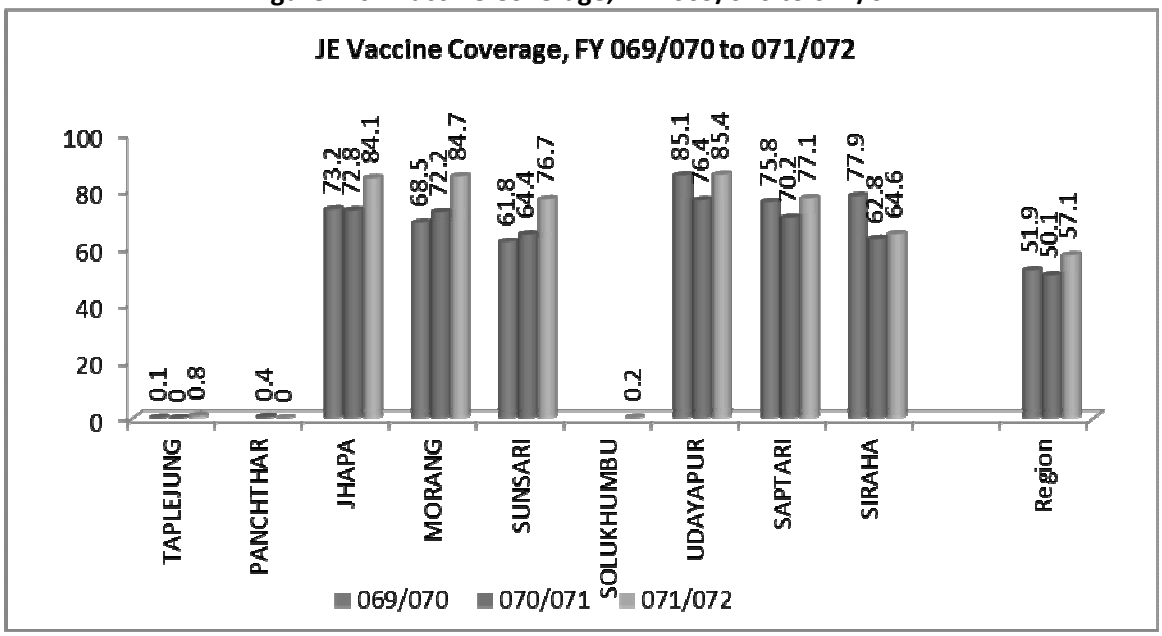
Table 2 shows immunization coverage for the last three years in eastern region. BCG coverage for FY 071/072 has decreased by 7 percent compared to FY 070/071. BCG coverage was highest in Siraha (116%) and lowest in Solukhumbu (80%).

Likewise, DPT-HepB-Hib 3 coverage in FY 071/072 has decreased by 6 percent compared to FY 070/071, and increased by 2 % as compared to FY 069/070. In this fiscal year, DPT-HepB-Hib 3 coverage was highest in Panchthar (104%) and lowest in Solukhumbu & Okhaldhunga (79%).

The region was able to achieve target of 90 percent Measles coverage in all but Taplejung, Ilam, Dhankuta, Terhathum, Bhojpur, Solu, Okhaldhunga and Sirha could not achieve this value. Overall, Measles coverage decreased by 8% compared to FY 070/071. In this fiscal year, Measles coverage was highest in Sankhuwasava (96%) and lowest in Solukhumbu & Okhaldhunga (79%).

Similarly, the trend of coverage of TT2 &TT2+(Td) vaccination in pregnant women in the last three years is on steady increase. The coverage at regional level in FY 071/072 was 79 percent which was 7 percent more than FY 070/071. In this fiscal year, TT2 &TT2+ coverage has been highest in Saptari (91%) and lowest in Dhankuta (61%).

Figure 2: JE Vaccine Coverage, FY 2069/070 to 071/072



A total of nine out of sixteen districts are at risk of Japanese Encephalitis in eastern region. As shown in Figure 2, overall coverage of JE vaccine in the region is fluctuating over the three years period and increased from 51.9 percent in FY 2069/70 to 57.1% percent in FY 071/072. Problems in supply of vaccine in time is reported for being the cause for low coverage. The coverage of JE was highest in Udaypur (85.4%) and lowest in S0lu (0.2%) & null this year Panchthar.

Table 3: Drop-out Rates, by Districts, FY 2069/070 to 071/072

Districts	Drop Out Rate DPT-HepB-Hib-1 vs DPT-HepB-Hib-3			Drop Out Rate BCG Vs Measles		
	069/070	070/071	071/072	069/070	070/071	071/072
TAPLEJUNG	-0.26	0.54	4.04	1.91	6.18	8.52
PANCHTHAR	-0.93	-0.55	0	2.1	-1.15	-1.97
ILAM	2.52	-2.48	1.52	4.69	-2.12	1.94
JHAPA	0.65	1.65	2.6	9.93	9.36	2.37
MORANG	2.7	0.74	3.88	14.68	21.15	10.90
SUNSARI	4.51	3.72	4	11.83	6.03	-0.23
DHANKUTA	-0.36	0.28	0.72	1.66	2.3	0.28

TERHATHUM	3.79	-0.46	5.28	9.86	3.77	5.81
SANKHUWASABHA	1.71	4.7	0.12	6.53	3.41	-31.21
BHOJPUR	2.85	-0.22	1.73	7.15	0.2	3.55
SOLUKHUMBU	1.79	3.06	3.52	9.46	1.81	-4.12
OKHALDHUNGA	-0.42	-0.54	5.9	13.28	5.2	2.77
KHOTANG	1.47	2.57	1.86	9.57	0.25	1.75
UDAYAPUR	4.64	1.45	7.59	8.01	10.44	4.62
SAPTARI	2.2	2.69	2.06	4.51	2.16	1.91
SIRAHA	7.19	7.28	11.95	12.13	12.15	26.81
Region	2.82	2.26	**4.24**	9.64	8.81	**5.94**

Table 3 shows dropout rates for the last three years. In FY 071/072, the dropout rate of DPT-HepB-Hib-1 vs DPT-HepB-Hib-3 was 4.24 percent as compared 2.26 percent in FY 070/071.This table also shows that dropout rate of DPT-HepB-Hib-1 vs DPT-HepB-Hib-3 was negative in Bhojpur, Illam, Okhaldhunga, and Terhathum district in FY 2070/71 and was null in Panchthar this year. The dropout rate of DPT-HepB-Hib-1 vs DPT-HepB-Hib-3 has remained within acceptable point of < 10% for last three FYs.

Similarly, in FY 070/071, the dropout rate of BCG vs Measles was 5.94 percent compared to 9.6 and 8.81 percent in FY 070/071 and 2069/70 respectively. It presents us the situation that utilization of measles vaccine is quite low (dropout just below 10%) as compared to BCG and effort should be made to further reduce the dropout below 10% as far as possible. Morang, and Siraha reported dropout rate of BCG vs Measles above 10% and alarmingly dropout for Siraha has remained continuously high 26.8 % for last three FYs. Dropout for BCG Vs Measles was 10.9 % in Morang in FY 071/072.

Table 4: Vaccine Wastage Rate by Districts, FY 2069/070 to 071/072

Districts	Vaccine Wastage Rate- DPT - Hep B -Hib (%)			Wastage Rate- Polio Vaccine (%)			Vaccine Wastage Rate- BCG (%)			Vaccine Wastage Rate- Measles (%)		
	069/070	070/071	071/072	069/070	070/071	071/072	069/070	070/071	071/072	069/070	070/071	071/072
TAPLEJUNG	27.9	34.1	41.7	33.7	35.1	39.7	90.4	86.6	88.0	80.1	80.2	78.4
PANCHTHAR	20.9	23.7	22.2	21.8	24.1	26.2	88.4	88.1	86.1	78.7	78.7	76.6
ILAM	18.2	25.7	32.1	19.3	26.0	29.9	85.1	86.0	85.4	71.5	71.2	74.5
JHAPA	9.8	13.3	12.2	11.7	13.2	11.8	61.7	86.9	59.9	38.9	42.5	40.9
MORANG	7.8	9.5	7.5	8.2	9.2	8.3	60.7	61.9	58.4	39.1	41.5	35.6
SUNSARI	15.5	18.2	17.3	18.3	19.4	16.9	72.8	71.6	66.5	55.6	55.4	50.1
DHANKUTA	25.6	31.0	29.0	28.4	30.3	29.8	86.8	86.6	84.5	75.5	75.3	71.6
TERHATHUM	34.2	41.5	42.7	39.6	44.8	42.4	90.2	89.7	88.9	83.0	80.9	79.1
S.SABHA	27.3	30.8	29.1	28.4	31.6	29.3	90.5	89.3	87.9	81.9	81.3	69.2
BHOJPUR	29.6	36.9	34.1	33.3	39.6	34.0	88.9	89.1	87.7	78.3	78.2	76.6
SOLU	30.9	37.3	46.6	39.3	39.4	46.8	86.9	86.6	87.1	76.2	76.0	74.7
O.DHUNGA	51.6	57.1	52.6	56.5	60.2	55.8	91.3	90.1	89.6	84.4	84.8	75.9

KHOTANG	42.3	50.1	53.2	44.6	51.2	53.6	88.5	89.8	89.0	80.7	81.9	81.2
UDAYAPUR	25.1	29.1	25.5	29.3	33.3	27.2	83.4	82.4	78.8	70.5	69.6	66.6
SAPTARI	30.4	29.8	30.9	34.7	33.3	34.0	84.9	81.5	79.9	72.7	70.5	69.5
SIRAHA	15.4	17.7	14.3	16.6	18.1	13.3	81.0	79.6	72.1	63.6	66.6	65.2
Region	20.9	24.5	**24.3**	23.8	26.0	**24.8**	81.1	82.5	**77.6**	66.9	67.1	**63.8**

Table 4 shows the vaccine wastage rate in the last three years. For DPT-HepB-Hib the wastage rate has remained static, as it was 24.5 percent in FY 070/071, 20.9% in FY 069/070 and highest at 24.5 percent in FY 070/071. It is alarming that wastage rate has remained high than recommended wastage rate of 5 percent for single dose vial. Out of sixteen districts of this region all the districts had higher vaccine wastage rate than the recommended wastage rate. Khotang has the highest wastage rate (53.2%) and Morang has the lowest (7.5%).

Similarly wastage rate of OPV was 24.8 percent in FY 071/072 compared to 26 percent in 070/071 and 23.8 percent in 069/070 which is well above the recommended wastage rate of 15 percent. Out of 16 districts, only Jhapa (11.8%), Morang (8.3%) and Siraha (13.3%) had lower than the recommended wastage rate. Vaccine wastage rate of BCG (77.6 percent) and Measles (63.2 percent) showed decreasing as compared to the previous fiscal years.

Access and Utilization of Immunization Services

Evaluation of access of immunization services are based on first dose of DPT-HepB-Hib coverage (>90% as good access), while utilization of immunization services are evaluated against drop-out rate DPT-HepB-Hib1 against DPT-HepB-Hib3 (<10% drop-out as good utilization). Districts are categorized and prioritized in 4 groups based on 'access' and 'utilization' of DPT-HepB-Hib vaccine.

Category 1 includes districts with high coverage (>90%) and low drop-out (<10%) and are considered as districts with good access and utilization, category 2 includes districts with high coverage (>90%) and high drop-out (>10%) and are considered as districts with good access but poor utilization, category 3 includes districts with low coverage (<90%) and low drop-out (<10%) and are considered as districts with poor access and good utilization and category 4 includes districts with low coverage (<90%) and high drop-out (>10%) and are considered as districts with poor access and poor utilization.

For this FY 071/072, 13 districts remained at Category 1, 1 district i.e Siraha in category 2, Dhankuta and Solukhambu in category 3 and no districts in category 4 .

Full immunization declaration

Districts	Total		Declared		To be declared	
	VDCs	Municipalities	VDC	Municipalities	VDCs	Municipalities
Solukhambu	30	1	0	0	30	1
Okhaldhunga	50	1	10	0	40	1
Khotang	72	1	2	0	70	1
Udayapur	40	3	4	0	36	3
Saptari	94	4	18	2	78	2
Sunsari	39	5	1	0	38	5
Morang	50	8	28	1	22	7
Jhapa	29	8	3	1	26	7
Ilam	43	3	43	3	0	0
Panchthar	38	1	18	0	20	1
Taplejung	48	1	0	0	48	1
Sa.Sava	25	3	24	1	1	2

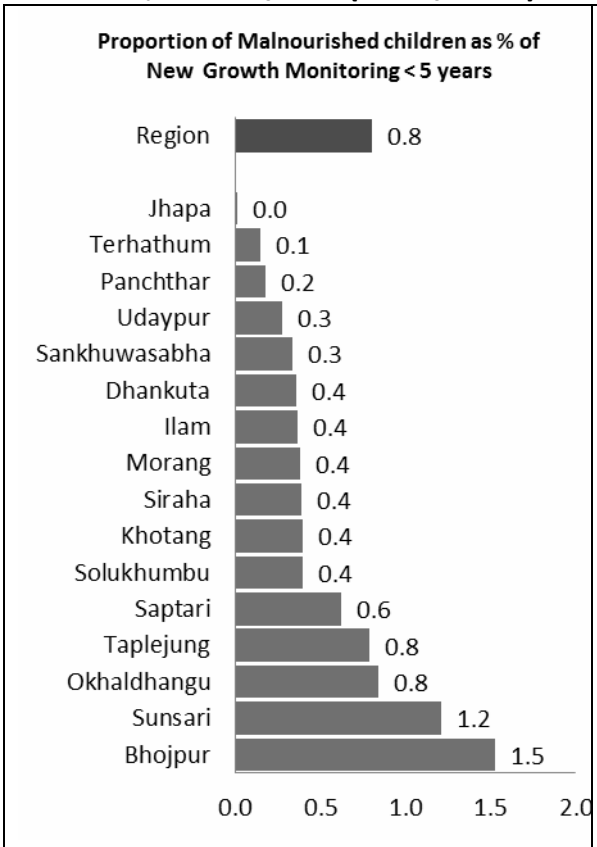
Dhankuta	28	2	28	2	0	0
Terhathum	21	2	21	2	0	0
Bhojpur	54	2	27	0	27	2
Siraha	76	4	0	0	76	4
Total	967	63	228	12	739	51

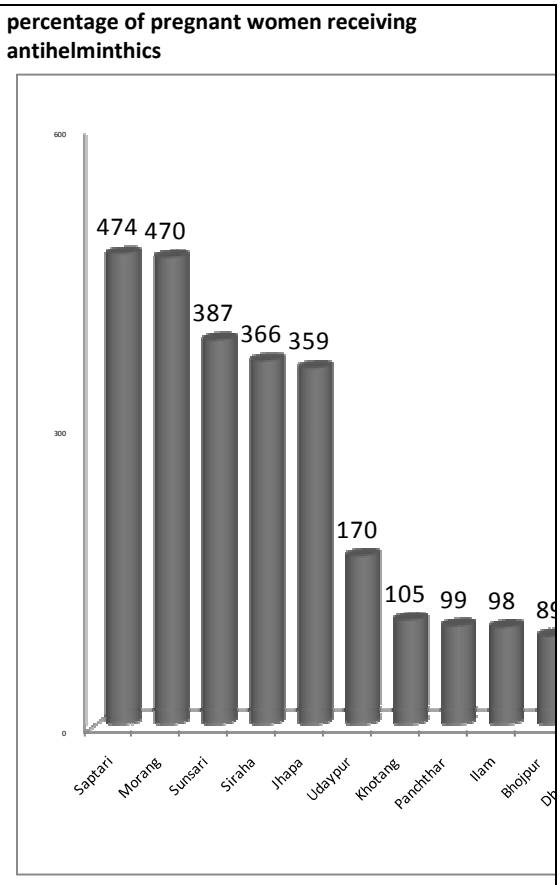
2.1.4 Issues, Problems/Constraints and Action to be Taken

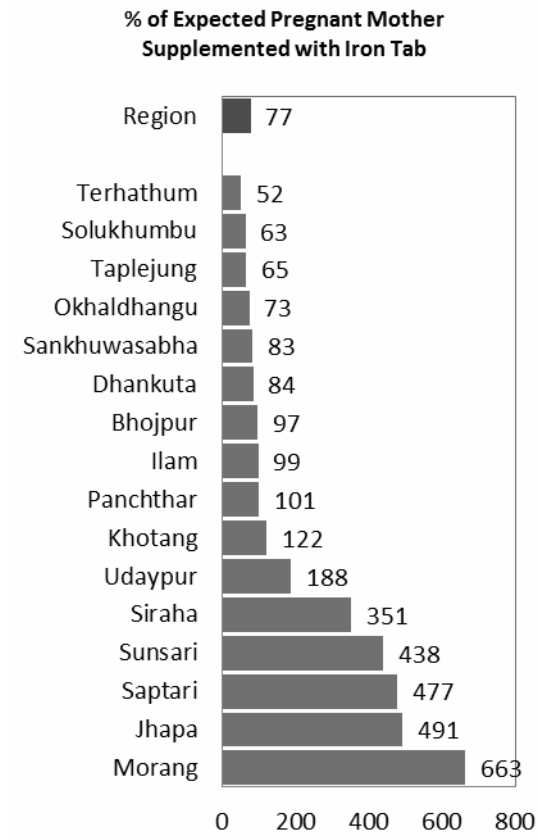
Major Achievement	Performance Gap	Causes/reason	Recommended action for improvements
All districts have high coverage except solu and Okhaldhunga	Quality of immunization data	inadequate periodic review and analysis of data, immunization focal person not monitoring the data	Provision of DQSA to all districts every year and regular supervision and feedback by expert
3 districts ,228 VDCs and 12 municipality declared fully immunized in the region	13 districts,739 VDCs and 51 municipalities yet to be declared by 2017(3 districts Siraha, Solu and Taplejung not initiated fully immunization declaration yet)	Waiting for jointly declared with ODF, inadequate budget, local governance institutions not taking responsibility ,No mandatory to declare	Improve budget and ensure sustainability of the program, local governance institutions should take responsibility and it should made mandatory to declare

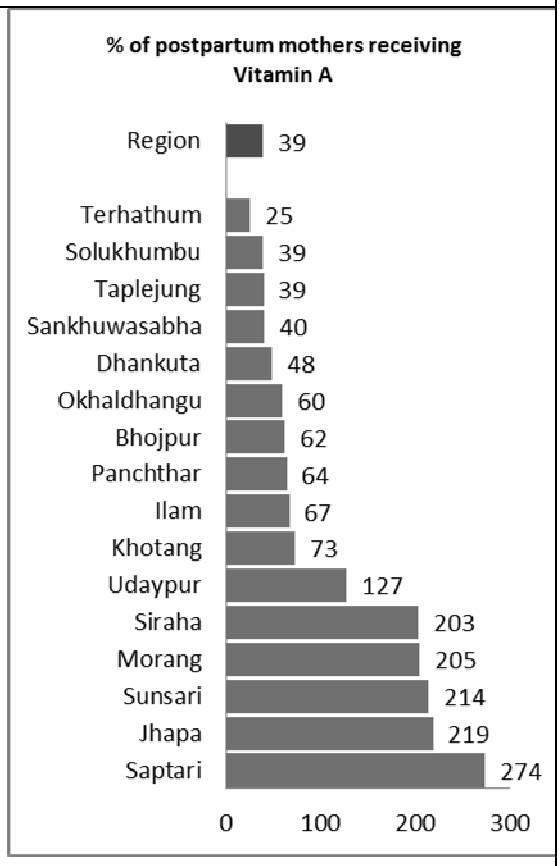
Conclusion: Overall immunization coverage is good in the region i.e. 95% coverage of all antigens. BCG coverage meets the national target (>90%). Negative drop out in few districts and low coverage for JE vaccine were the major issues in the region.

Nutrition, FY 071/072 (2014/2015)









2.2 NUTRITION

2.2.1 Background

Nutrition plays key role in growth and development for maintaining quality of life. Malnutrition remains as a serious obstacle to child survival, growth and development in Nepal and in eastern region. The commonest form of malnutrition is protein-energy malnutrition (PEM). Major causes of PEM in Nepal is low birth weight (< 2.5 kg) , poor maternal nutrition, inadequate dietary intake, frequent infections, household food insecurity, feeding behavior, poor care and practices leading to an intergenerational cycle of malnutrition. According to Nepal Demographic and Health Survey (NDHS, 2011), 37 percent of children below 5 years of age are stunted, 25 percent of the children are underweight and 10 percent of the children below 5 years are wasted in this region (MoHP, New ERA, and ICF International Inc., 2012). The other forms of malnutrition are iodine, iron and vitamin A deficiency.

The main policy document, a National Nutrition Policy and Strategy was formulated in 2004 AD which has been guiding the nutrition interventions in the health sector. The MoHP has also put in place School Health and Nutrition Strategy 2006. Similarly, Nepal Health Sector Program II 2010-2015 (NHSP II) has given a special priority for nutrition and has also emphasized on the need for a multi-sectoral approach.

The overall goal of nutrition program is to achieve nutritional well-being of all people to maintain a healthy life to contribute in the socio-economic development through improved nutrition program implementation in collaboration with relevant sectors (DoHS, 2012).

The general objective of the National Nutrition Program is to enhance nutritional well-being, reduce child and maternal mortality and is to contribute for equitable human development. The specific objectives are (DoHS, 2070/71):

- To reduce protein-energy malnutrition in children under 5 years of age and women of
- reproductive age
- To reduce the prevalence of anemia among adolescent girls, women and children
- To virtually eliminate iodine deficiency disorders and vitamin A deficiency and sustain the
- Elimination
- To reduce the infestation of intestinal worms among children and pregnant women
- To reduce the prevalence of low birth weight
- To improve household food security to ensure that all people can have adequate access,
- availability and utilization of food needed for healthy life
- To promote the practice of good dietary habits to improve the nutritional status of all people
- To prevent and control infectious diseases to improve nutritional status and reduce child
- mortality
- To control the incidence of life-style related diseases (coronary artery disease, hypertension,
- tobacco and smoke related diseases, cancer, diabetes, dyslipidemia, etc.)
- To improve health and nutritional status of school children
- To reduce the critical risk of malnutrition and life during exceptionally difficult circumstances
- To strengthen the system for analyzing, monitoring and evaluating the nutrition situation
- To align the health sector programs on nutrition with Multi-sectoral Nutrition Initiative

- To improve the maternal nutrition

2.2.2 Major Activities

The following were the major activities carried out during FY 2071/72:

- Purchasing of first aid treatment kits for school.
- Integrated child health review at community levels
- Growth monitoring of under five years children
- Vitamin A distribution program
- Celebration of breast feeding week
- Advocacy of IDD month
- Celebration of school/nutrition week.
- FCHVs mobilization of national vitamin A program.
- Iron tablets distribution to pregnant women.
- Albendazole tab distribution to pregnant women and children.
- Supervision and monitoring of integrated child health program.

2.2.3 Analysis of Achievement

Table 5: Nutrition Program by Districts, FY 2069/070 to 071/072

Districts	New Growth Monitoring (%) <1 years			New Growth Monitoring (%) <5 years			Underweight Children among New visits (%)		
	069/070	070/071	071/072	069/070	070/071	071/072	069/070	070/071	071/072
Taplejung	401.8	113.8	134.2	87.8	26.1	3.3	5.75	1.90	0.07
Panchthar	108.4	110.4	147.5	33.7	38.1	2.4	0.36	0.17	0.01
Ilam	103.5	110.9	213.6	43.9	51.7	3.0	0.35	0.45	0.02
Jhapa	98.4	111.8	631.6	52.4	47.2	2.9	0.54	1.83	0.06
Morang	103.2	116.9	724.3	36.0	37.8	3.1	4.01	1.40	0.05
Sunsari	68.3	80.7	447.6	23.8	29.4	2.7	2.05	2.20	0.08
Dhankuta	96.1	108.8	122.9	30.9	31.3	3.8	0.33	0.23	0.01
Terhathum	106.4	108.5	72.8	41.9	31.5	3.5	0.14	0.34	0.01
S.saha	108.5	114.1	141.1	36.1	43.0	2.8	1.16	1.29	0.05
Bhojpur	96.0	103.5	159.7	48.6	51.8	3.6	0.17	0.24	0.01
Solukhumbu	146.7	153.6	117.3	77.6	85.1	5.2	0.87	1.52	0.05
O.hunga	93.3	90.6	142.7	72.0	65.9	3.0	2.28	1.65	0.06
Khotang	130.4	117.2	164.1	56.5	58.4	2.8	1.54	0.97	0.03
Udaypur	110.4	112.0	291.8	40.5	40.2	2.8	1.85	2.32	0.08
Saptari	98.7	107.6	609.1	44.0	53.6	2.5	4.80	2.98	0.10
Siraha	108.6	103.8	373.5	23.6	24.4	2.1	1.25	0.97	0.03
Region	105.8	107.2	**98.9**	40.5	41.1	**2.9**	2.21	1.63	**0.73**

Table 5 shows that percentage of new growth monitoring <1 year of age has remained comparatively higher than percentage of new growth monitoring <5 years of age in the region for all the FYs which suggests for increased focus on new growth monitoring of age between 1 to 5 years.

Likewise, Table 5 also shows the regional and district trend in nutritional status (under nutrition) of children <5 years from fiscal year 069/070 to 071/072. At the regional level, the reported percent of under five years children among new growth monitored having underweight status has decreased to 0.73 % which is far below the finding of NDHS, 2011 (25% underweight).

Among the districts of this region, Saptari (0.10%), has comparatively higher percentage of underweight <5 years children whereas all the sixteen districts of ER has reported only <1% underweight children.

Table 6: Nutrition Program by Districts, FY 2069/070 to 071/072

Districts	% of pregnant woman receiving Anthelminthic			% of pregnant woman receiving Iron Tabs (new)			% of postpartum mothers receiving Iron Tabs			% of postpartum mothers receiving Vitamin A		
	069/070	070/071	071/072	069/070	070/071	071/072	069/070	070/071	071/072	069/070	070/071	071/072
Taplejung	243.3	117.0	64.6	98.4	89.7	65.0	55.3	58.9	39.4	54.7	57.2	39.0
Panchthar	79.1	87.1	99.3	79.2	87.2	101.0	52.1	58.4	64.3	52.2	58.5	64.0
Ilam	56.6	59.8	97.9	61.3	60.9	99.0	38.5	36.6	56.7	41.9	44.3	67.0
Jhapa	65.3	75.0	359.0	73.6	78.3	491.0	42.7	52.7	209.7	46.0	57.1	219.0
Morang	60.3	67.3	469.8	68.3	74.9	663.0	32.0	36.0	223.3	80.5	64.6	205.0
Sunsari	64.8	67.1	387.0	81.0	80.3	438.0	44.3	44.4	206.6	88.1	58.5	214.0
Dhankuta	68.4	72.9	82.8	74.7	75.4	84.0	51.5	56.1	44.8	55.5	60.5	48.0
Terhathum	69.1	82.7	50.7	69.9	82.9	52.0	36.5	42.5	25.2	40.6	46.7	25.0
S.sava	68.6	77.3	82.3	68.9	80.7	83.0	45.9	40.9	43.9	47.4	41.5	40.0
Bhojpur	63.3	70.1	89.4	64.3	72.2	97.0	53.7	58.3	71.7	54.6	58.2	62.0
Solu	79.3	91.0	59.4	88.5	111.6	63.0	51.2	59.2	39.4	52.9	56.3	39.0
O.dhunga	72.5	65.6	70.0	72.5	66.4	73.0	64.7	64.4	61.0	59.0	65.4	60.0
Khotang	79.6	78.0	105.2	96.3	91.8	122.0	61.3	57.2	86.6	61.7	59.6	73.0
Udaypur	73.0	97.8	170.0	74.9	87.1	188.0	36.9	40.3	130.6	37.1	40.1	127.0
Saptari	99.8	102.6	473.7	99.9	102.5	477.0	60.1	68.8	282.3	62.3	70.2	274.0
Siraha	104.1	103.3	366.0	103.8	118.2	351.0	78.0	61.6	206.2	79.0	62.2	203.0
Region	76.9	80.7	67.6	80.0	85.9	77.0	48.2	50.7	40.00	63.8	58.9	39.0

Table 6 shows the regional and district trend of Iron & anthelminthic tablets received by pregnant women from FY 069/070 to 071/072. Table 6 also shows the trend of Iron & Vitamin A distribution for postpartum mothers from FY 068/069 to 070/071. At the regional level, the percentage of pregnant women receiving iron tablets decreased as compared to the last FY 070/071, from 85.9% to 77% in FY 071/072.

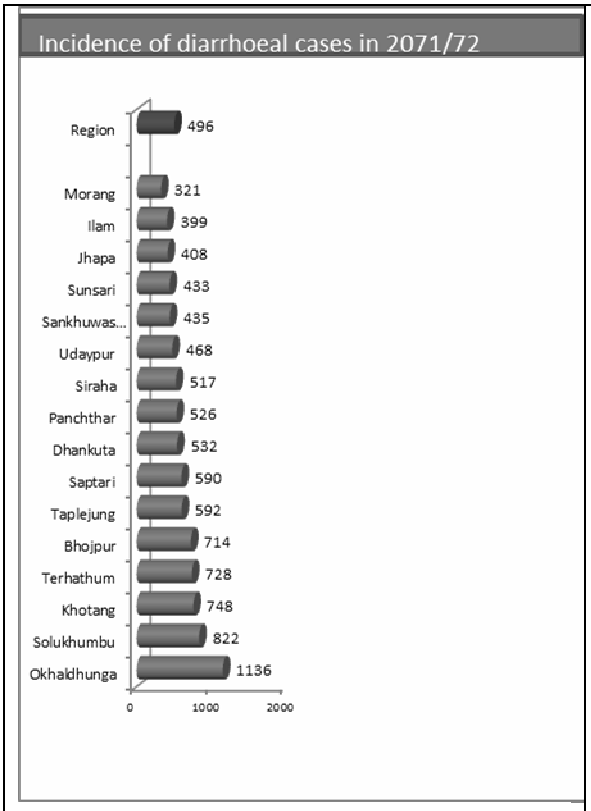
Similarly, anthelminthic tablet distribution has also decreased in FY 071/072 as compared to last to FYs. However, iron tablet distribution was higher than anthelminthic distribution in last two fiscal years which should have been principally same. The trend of percentage of postpartum mothers receiving Iron tablets is fluctuating over the period of last three FYs. However, percentage of postpartum mothers receiving Vitamin A shows a fluctuating trend, with nearly 20% decrease as compared to previous FY 2069/70.

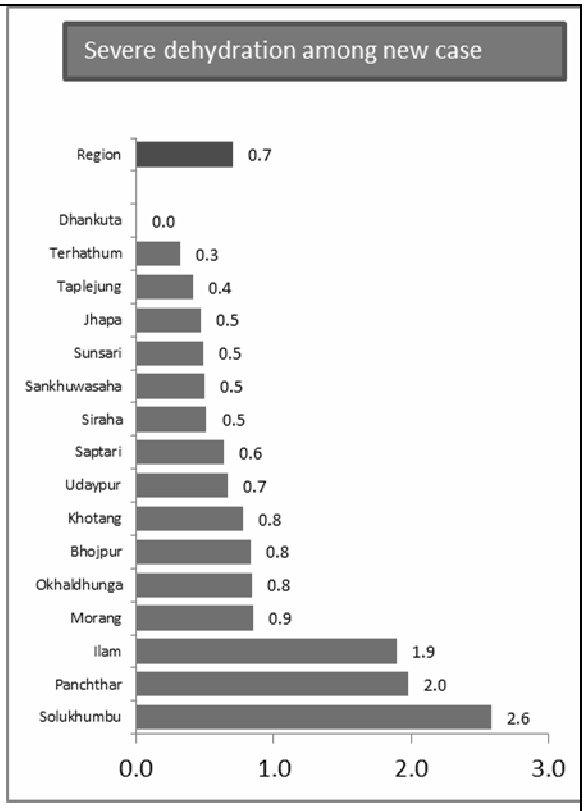
2.2.4 Issues, Problems/Constraints and Action to be Taken

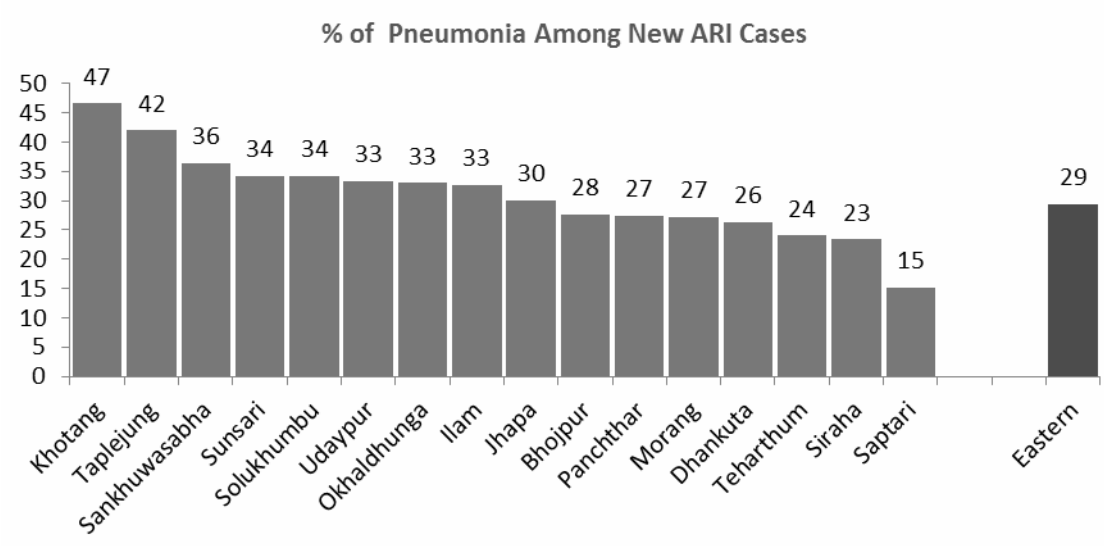
Major Achievement	Performance Gap	Cause/Reasons	Recommended actions for improvement
The proportion of malnourished children is in decreasing trend	Less growth monitoring of children above one year	inadequate BCC activates to motivate growth monitoring	Activities that motivate growth monitoring of above one year children should be conducted
	Basic training to the new HWs	Inadequate capacity enhancement programs	Increase the quota for HWs training and conduct training either in district or regional level

Community Based – Integrated Management of Childhood and Neonatal Illness

(CB-IMNCI), FY 2071/72







2.3 Community Based Integrated Management of Neonatal and Childhood Illness (CB-IMNCI)

2.3.1 Background

Community Based Integrated Management of Childhood Illness (CB-IMCI) Program is an integrated package of child-survival interventions and addresses major childhood killer diseases like Pneumonia, Diarrhoea, Malaria, Measles, and Malnutrition in 2 months to 5 year children in a holistic way. CB-IMCI also includes management of infection, Jaundice, Hyperthermia and counseling on breastfeeding for young infants less than 2 months of age. With the implementation of this package children are diagnosed early and treated appropriately for major childhood diseases at the health facility and community level. At the community level FCHVs are the main vehicle of service delivery and also plays key role to increase community participation.

The goal of this program is to reduce morbidity and mortality among children under-five due to pneumonia, diarrhoea, malnutrition, measles and malaria.

The objectives of this program are:

- Reduce frequency and severity of illness and death related to ARI, Diarrhoea, Malnutrition, Measles and Malaria.
- Contribute to improve growth and development.

2.3.2 Major Activities

Major activities carried out in the FY 2071/72 include the following:

- CB-IMNCI program has been implemented in Taplejung, Sankhuwasava and Bhojpur
- Management of sick under five children through health facilities and community health workers and FCHVs.
- Purchasing of ORS/Zinc, Cotrim PD and second line drug for IMCI
- Celebration of Pneumonia day.

2.3.3 Analysis of Achievement

The table 7 below shows the total number of cases for less than 2 months was in decreasing trend for last three FYS at regional level. Higher numbers of cases were reported in Morang, Jhapa and Sunsari whereas lower numbers of cases were reported in Panchthar and Illam districts. There has been a fluctuating trend in the number of cases treated for SBI, LBI, Low weight and hyperthermia over the three years period. LBI cases were reported highest which was 8132 in number and was lowest cases were of hyperthermia (190) in FY071/072. Death cases reported has been in decreasing trend with a total of 5 deaths reported in FY 071/072. Feeding problems, Treatment by Gentamycin and Cotrimoxazole, referrals is in decreasing trend.

Table 7: Classification and Treatment of <2-Month Cases, by Districts from 2068/069 to 071/072

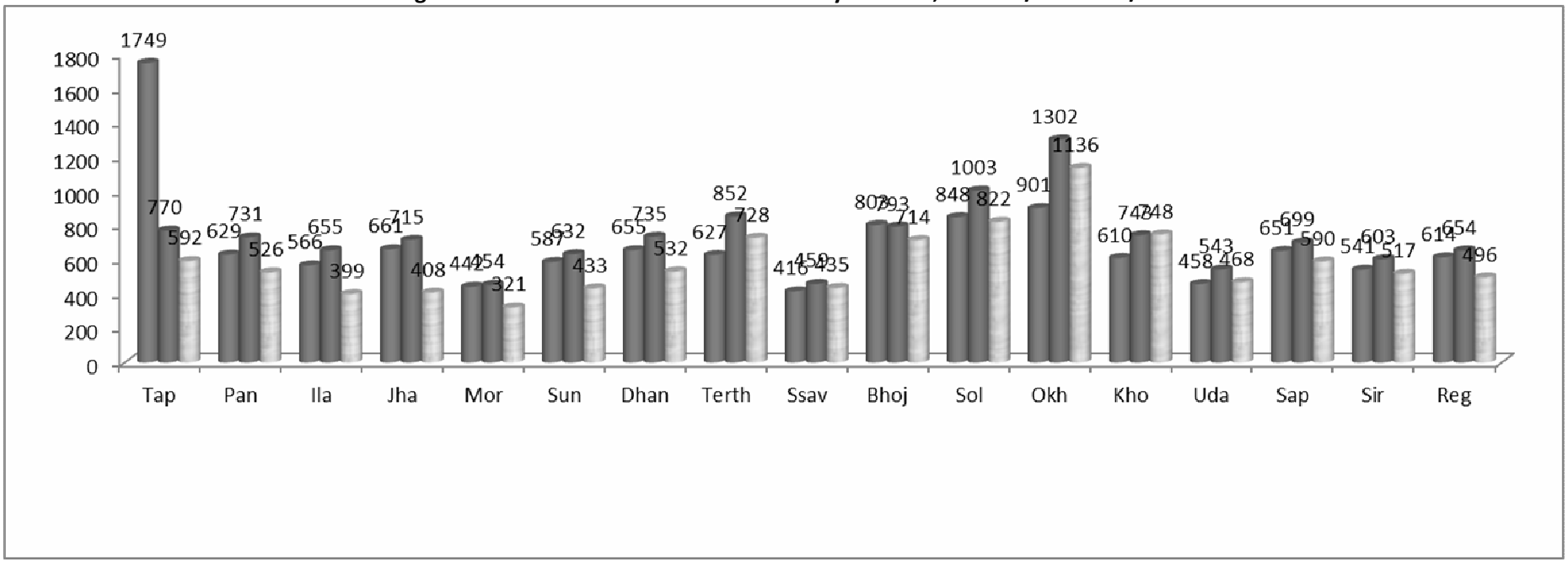
Districts	F.Y.	Taplejung	Panchthar	Ilam	Jhapa	Morang	Sunsari	Dhankuta	Teharthum	S.Sabha	Bhojpur	Solu	O.dhunga	Khotang	Udayapur	Saptari	Siraha	Region
Total	069/070	742	297	162	1605	2516	1434	736	286	890	381	664	357	769	722	1249	764	**13574**
	070/071	751	213	216	1853	1991	1199	543	310	581	422	667	291	888	589	917	723	**12154**
	071/072	813	282	128	1868	2099	1948	685	359	581	656	714	555	1096	887	1182	678	14531
SBI	069/070	29	26	16	112	727	227	95	22	74	68	6	17	66	80	122	110	**1797**
	070/071	50	36	9	89	515	174	54	24	61	91	51	23	71	100	52	63	**1463**
	071/072	21	49	16	118	457	141	60	40	70	45	32	46	54	151	66	59	**1425**
LBI	069/070	233	180	122	970	630	633	218	130	267	231	253	184	473	449	839	495	**6307**
	070/071	359	126	76	1289	641	598	189	184	192	223	231	168	593	360	674	525	**6428**
	071/072	597	168	88	1253	908	835	252	254	213	361	345	350	623	629	878	378	**8132**
Jaundice	069/070	40	1	11	105	40	26	22	9	61	20	7	14	46	50	8	13	**473**
	070/071	25	0	9	158	27	35	24	4	12	21	15	11	36	33	2	4	**416**
	071/072	21	2	6	125	41	57	25	35	31	13	48	27	45	56	10	9	**551**
Hyperthermia	069/070	67	0	0	7	0	10	1	6	11	1	4	5	8	2	21	0	**143**
	070/071	14	0	1	19	3	6	0	0	2	1	14	3	25	8	27	2	**125**
	071/072	17	5	4	21	8	9	10	5	15	18	12	14	24	11	5	12	**190**
Feeding Problem/Low Weight	069/070	71	56	14	226	104	88	71	31	135	52	41	53	50	50	110	37	**1189**
	070/071	110	24	13	205	44	87	56	23	42	45	80	27	102	45	46	10	**959**
	071/072	23	15	22	223	72	64	69	23	18	37	86	43	59	34	70	27	**885**
Treatment by Cotrimoxazole	069/070	215	114	52	759	1178	844	259	98	106	143	296	103	298	244	715	329	**5753**
	070/071	385	73	51	1098	953	627	202	153	137	121	286	90	393	268	557	278	**5672**
	071/072	691	127	51	637	1190	1257	229	183	168	235	303	208	560	442	850	233	**7364**
Treatment by Gentamycin	069/070	53	54	27	172	727	214	86	15	54	58	25	13	73	67	163	168	1969
	070/071	68	34	19	183	467	223	57	15	43	85	21	16	68	112	81	143	1635
	071/072	26	39	6	47	877	252	41	15	64	16	63	26	47	141	36	55	**1751**
Refer	069/070	25	10	18	104	36	43	14	20	48	31	23	28	59	29	54	67	**609**
	070/071	20	9	12	215	54	59	11	9	16	13	19	11	34	23	20	36	**561**
	071/072	8	16	6	211	61	60	16	6	24	11	18	19	35	40	27	37	**595**
Death Cases	069/070	9	0	2	0	0	99	2	0	2	2	3	1	5	0	0	0	**125**
	070/071	28	0	2	0	0	0	4	1	74	101	7	3	0	1	0	0	**221**
	071/072	3	0	4	1	3	5	1	0	2	2	0	3	1	2	0	0	**27**

Table 8: Classification and Treatment of >2 Month Cases, by Districts from 2069/070 to 071/072

Districts	Incidence of Diarrheal Disease			Severe Dehydration among new Cases			% of diarrhoeal cases Treated by FCHV			Proportion of diarrhoeal cases treated by VHW/MCHW			Proportion of diarrhoeal cases treated by HF			Proportion of diarrhoeal cases treated by Zinc & ORS			Case fatality rate diarrhoeal		
Taplejung	1748.6	770.2	592.2	0.3	1.0	0.4	81.2	43.6	46.7	10.3	29.2	25.1	8.5	27.2	28.2	94.2	97.8	84.7	0	0.05	0
Panchthar	629.3	730.6	525.8	0.1	0.3	2.0	68.7	66.5	64.8	13.7	14.8	11.5	17.6	18.7	23.8	99.2	99.2	94.2	0	0	0
Ilam	566.2	654.8	399.4	0.1	0.1	1.9	68.9	68.1	74.7	21.4	22.3	11.9	9.8	9.6	13.4	96.1	99.1	90.7	0	0	12.8
Jhapa	660.8	715.2	408.1	0.2	0.1	0.5	65.7	69.6	63.5	14.9	14.3	11.6	19.4	16.1	25.0	97.6	98.8	88.6	0	0	0
Morang	442.1	453.6	321.4	0.1	0.1	0.9	69.9	72.1	70.3	12.7	12.4	9.5	17.4	15.6	20.1	97.5	98.8	97.0	0	0	0.28
Sunsari	586.6	632.0	432.6	0.1	0.2	0.5	69.8	70.2	69.6	11.4	11.6	8.3	18.8	18.2	22.1	99.3	99.3	77.1	0	0	0
Dhankuta	655.4	734.6	531.7	0.0	0.0	0.0	66.3	70.2	71.3	13.2	11.5	7.0	20.5	18.3	21.7	98.7	99.4	84.4	0	0	0
Terhathum	627.3	852.1	728.3	0.3	0.0	0.3	60.8	61.4	73.3	14.8	13.8	4.9	24.4	24.9	21.8	97.4	99.2	79.5	0	0.01	0
Sankhuwasaha	415.7	458.7	435.4	0.7	0.7	0.5	46.7	52.6	57.3	10.9	8.5	4.6	42.3	39.0	38.1	98.1	98.5	97.3	0.03	0.01	0
Bhojpur	803.0	793.0	714.3	0.0	0.2	0.8	60.9	59.9	69.3	14.7	15.6	8.1	24.4	24.5	22.7	98.6	99.0	86.8	0	0	2.23
Solukhumbu	847.7	1003.3	821.9	0.4	0.6	2.6	45.4	50.9	55.8	15.2	14.9	7.5	39.4	34.2	36.7	93.1	95.9	85.4	0.01	0.07	1.48
Okhaldhunga	901.1	1301.6	1136.1	0.6	0.3	0.8	58.4	62.4	73.0	14.8	13.6	6.5	26.8	24.0	20.4	95.8	98.5	77.0	0	0	4.76
Khotang	610.0	742.8	748.0	0.6	0.4	0.8	45.1	48.3	51.4	21.8	21.0	13.4	33.1	30.7	35.3	80.3	99.5	84.2	0	0	0
Udaypur	458.0	542.6	468.3	0.4	0.2	0.7	61.8	67.6	66.2	13.5	10.8	6.5	24.7	21.7	27.3	97.2	97.4	88.2	0	0	0.21
Saptari	651.0	699.2	590.1	0.1	0.1	0.6	51.6	49.0	59.0	18.3	19.5	13.0	30.1	31.5	28.0	98.9	98.8	80.5	0	0	0
Siraha	541.3	602.8	517.1	0.2	0.1	0.5	52.7	53.9	60.2	17.2	16.8	9.5	30.1	29.3	30.3	98.7	99.3	93.2	0	0	0.86
Region	613.8	653.9	496.2	0.2	0.2	0.7	62.4	61.9	64.5	14.9	15.4	10.1	22.7	22.7	25.5	97.2	98.8	86.6	0	0	0.75

Table 8 shows the incidence of diarrheal disease, which is fluctuating. It was highest in Okhaldhunga district and Solukhumbu. Severe dehydration cases among new cases have increased to 0.7% in this reporting fiscal year. The diarrhoeal case managed by FCHV in community level has been significant at 64.5% of the total cases as compared to those managed by VHW/MCHW (10.1%) and at HF (25.5%). There was decrement in the percentage of diarrheal cases treated by Zinc and ORS in FY 071/072 as compared to the previous FYs 069/070 and 070/071. The diarrheal case fatality rate in FY 071/072 has increased as that of previous FYs.

Figure 3: Trend of Incidence of ARI Cases by Districts, FY 2069/070 - 071/072

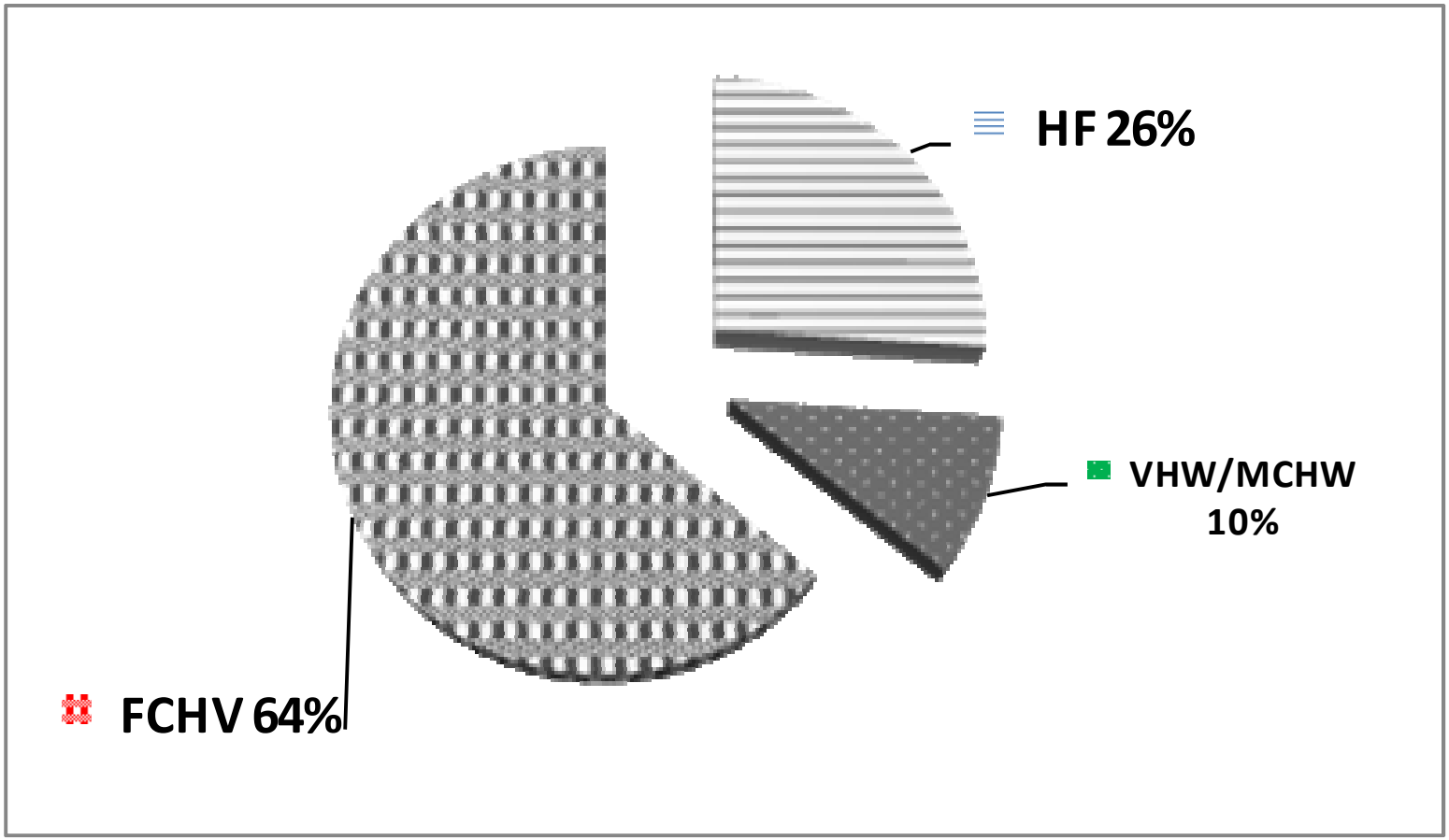


	Tap	Pan	Ila	Jha	Mor	Sun	Dhan	Terth	Ssav	Bhoj	Sol	Okh	Kho	Uda	Sap	Sir	Reg
069/070	1749	629	566	661	442	587	655	627	416	803	848	901	610	458	651	541	614
070/071	770	731	655	715	454	632	735	852	459	793	1003	1302	743	543	699	603	654
071/072	592	526	399	408	321	433	532	728	435	714	822	1136	748	468	590	517	496

Figure 3 shows the trend of incidence of new ARI cases per 1000 for < 5 years children at regional level. The incidence trend was decreasing in most of the districts except in Khotang. The regional average of incidence of ARI cases per 1000 for < 5 children of FY 071/072 was 496 with the lowest (361) in Morang and contrastingly the highest (1136) in Okhaldhunga districts.

Figure : Treatment of ARI cases at different levels, 2071/072

Figure 4 shows that out of total ARI cases, 26 % cases were treated at HFs, 10% were treated by VHWs/MCHWs and 64% were treated by FCHVs. This indicates 74% of ARI cases were treated at community level in FY 071/072 which is a significant impact of CB-IMCI program in the region.

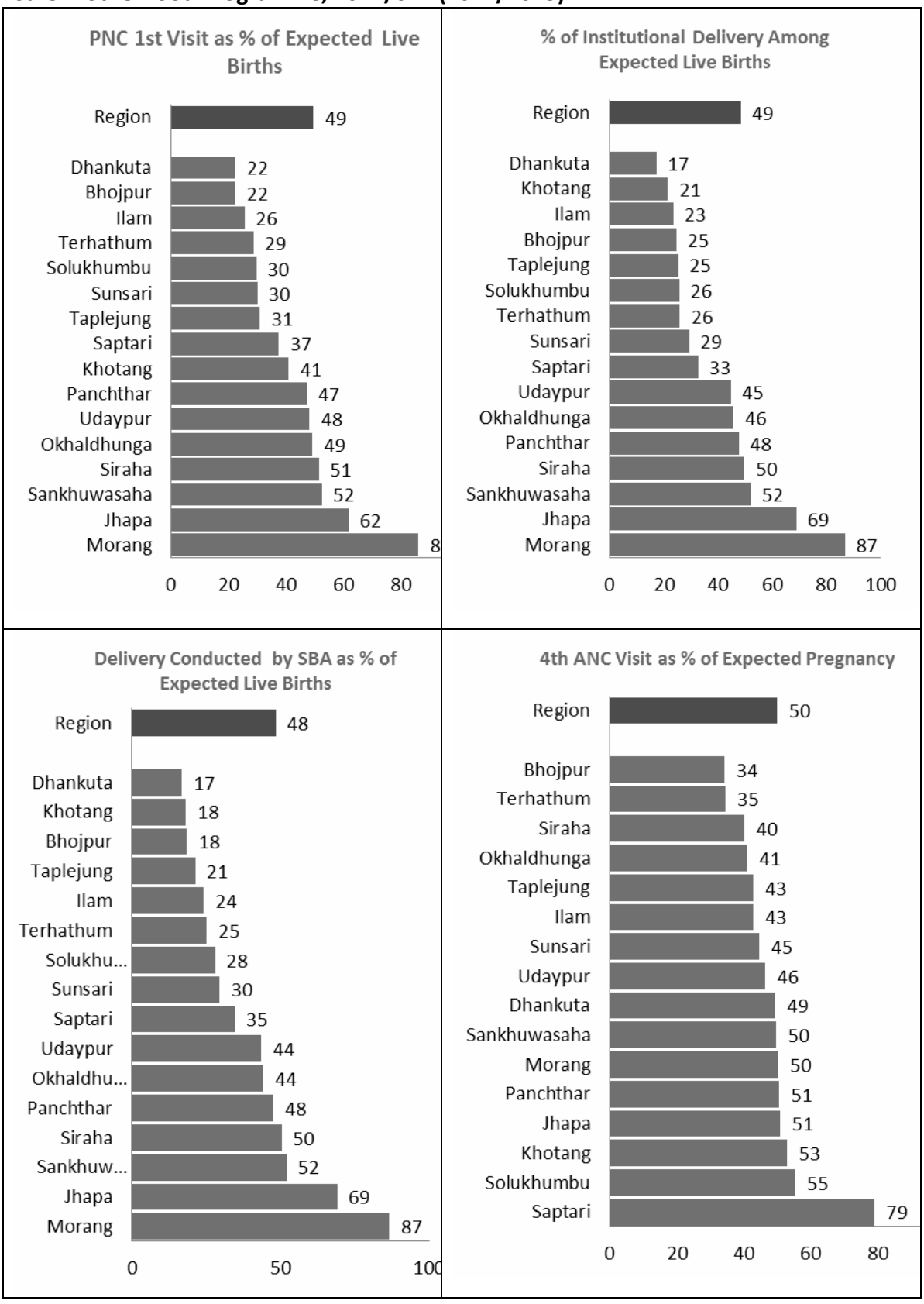


2.3.4 Issues, Problems/Constraints and Action to be Taken

Major Achievement	Performance Gap	Causes/Reason	Recommended actions for improvement
CB-IMCI and CB-NCP merged into CB-IMNCI and scaling up in the region	Untrained newly recruited health workers	slow scaling up of CB-IMNCI in the region	Provision of basic and refresher training to the health workers and Medical Officers.
	Supply of ORS, Cotrim-P not sufficient from the center (often unavailable in the local market)	Timely and adequate supply of the Cotrim-P. ORS to purchase locally by the districts	Ensure adequate and timely supply of key commodities

3 FAMILY HEALTH PROGRAM

Safe Motherhood Programme, 2071/072 (2014/2015)



3.1 SAFE MOTHERHOOD AND NEWBORN HEALTH

3.1.1 Background

The safe motherhood and newborn health is the priority programme of the region. The overall goal of the safe motherhood and newborn health programme of the region is guided by the national policies, programms and strategies such as SMNHLTP (2006-2017), NHSP-II (2010-2015) and MDGs.

Safe-motherhood and neonatal health aims at improving maternal and neonatal health and survival, especially of the poor and excluded. The programme aims to reduce maternal and neonatal mortalities by addressing factors related to various morbidities, death and disability caused by complications of pregnancy and childbirth. Like elsewhere, pregnancy-related complications are among the leading causes of death and disability for women age 15-49 both in the region and nation.

More than a decade of research has shown that small and affordable measures can significantly reduce the health risks that women face when they become pregnant. Most maternal deaths could be prevented if women had access to appropriate health care during pregnancy, childbirth and immediately afterwards. Newborn health and survival are also closely linked to the health of the mother before and during pregnancy, as well as during labour, childbirth, and the postpartum period. Key interventions for improving newborn health include: ensuring a skilled attendant at every birth; tetanus toxoid immunization; and immediate and exclusive breastfeeding.

Considering this, the ERHD made significant efforts to explore for better programming and planning within the region for strengthening safe motherhood and newborn health services through collaboration with non-state actors. With the initiation of the ERHD, joint supervision & monitoring visits were undertaken together with the I/NGOs and EDPs particularly in the selected low performing districts with the aim to support and strengthen safe motherhood and newborn health initiatives within the region. In addition, the district were encouraged to monitor institutional deliveries on monthly basis, identify the low performing birthing centers and conduct on-site coaching & mentoring to upgrade the performance of the skilled attendants.

Moreover, the ERHD made focused and coordinated efforts to monitor and update the human resources (SBAs, ASBAs, CEOC providers, OT nurses and anesthetic assistants) situation within the region and initiated lobby for the fulfillment of vacant positions at the regional level. In addition, the essential equipment and supplies required for the birthing centers and B/CEOC sites were also assessed from the region and coordinated with the center for needful actions along with explored possible supports from the local government and EDPs working in health sector.

Goal: Improved maternal and neonatal health and survival, especially of the poor and excluded.

Purpose: Increased healthy practices and utilization of quality maternal and neonatal health services, especially by the poor and excluded, delivered by a well-managed health sector.

3.1.2 Major Activities

The planned activities in safe motherhood and newborn health are more or less similar in all districts within the region. Some district might have additional activities and

programs mostly supported by the non-government sectors. Some major activities undertaken in FY 2071/72 were as follows:

- Conduction of Aama Surakchhya and Antenatal Incentive Program
- Antenatal, natal and postnatal care---A mother gets NRs. 400 if she completes 4 ANC visits as per the ANC protocol.
- Introduction of distribution of *Nyano Jhola* for postpartum mothers who have delivered at HFs.
- Safe abortion services- CAC, PAC and medical abortion
- Maternal & Neonatal Health Update- clinical update training provided to ANMs and Staff Nurses based on the standard SBA training package (participants were trained on the use of partographs, active management of third stage of labor (AMTSL) for prevention of PPH including conduction of normal labor, management of PPH, use of magnesium sulphate (MgSO4) for severe pre/eclampsia and neonatal resuscitation).
- On-site coaching and mentoring to improve quality of care and upgrade competencies of the skilled attendants.
- Expansion and maintenance of MNH activities at community level which includes revised Birth Preparedness Package (*Jeevan Suraksha* Flip Chart and *Jeevan Suraksha* Card) and *Matri Suraksha Chakki*(Misoprostol) distribution for prevention of postpartum haemorrhage (PPH)
- Screening and surgical camps for uterine prolapse
- Recruitment of ANMs on local contract to support 24-hour delivery services in HPs/SHPs and PHCCs.
- Expansion of birthing centers and B/CEOC sites for promoting institutional deliveries and management of emergency obstetric complications.
- Conducted meetings of Reproductive Health Coordination Committee (RHCC) on quarterly basis.

3.1.3 Analysis of Achievement

Figure 7: Safe Motherhood Programme, FY2069/70-2071/72

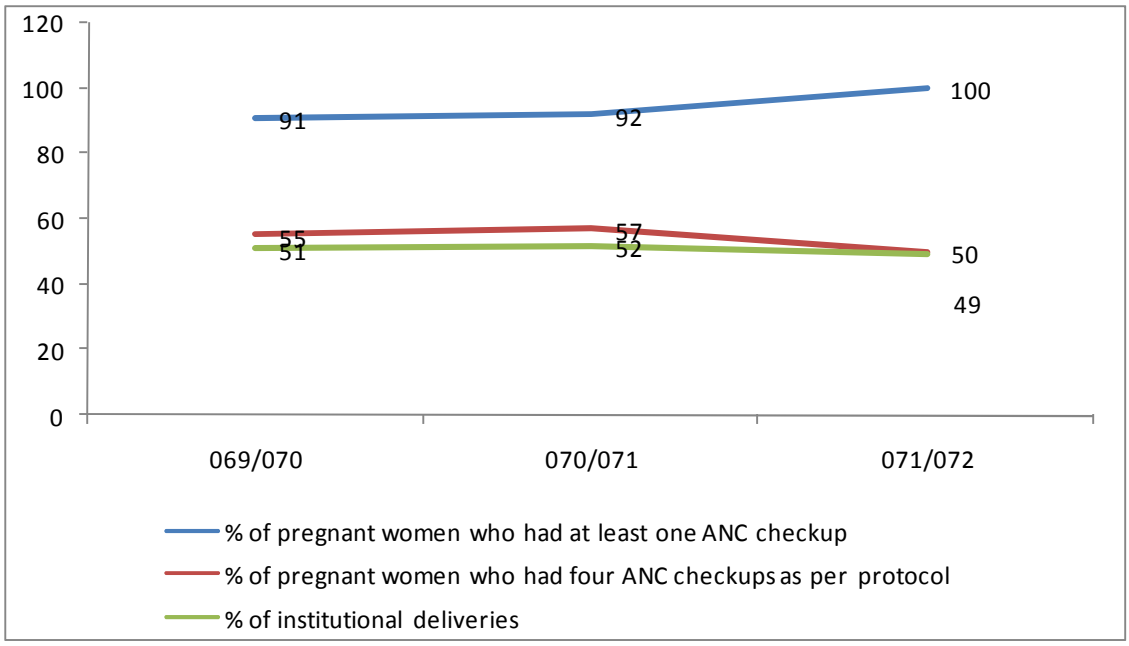


Figure 10 indicates that there is a significant gap between the first antenatal visit and institutional delivery at regional level; in fact data shows that the gap has remained same in the FY 071/072. ANC 4th visit as% 1st ANC visit has shown decreasing trend. However, 1st antenatal

visit was (100 %) and fourth antenatal visit (50 % out of first antenatal visit) in the last FY. The gap between fourth antenatal visit (50 percent) and institutional deliveries (49 percent) has however slightly decreased as compared to the previous FY 070/071.
Overall the trend of first antenatal visit is increased, 4th ANC out of first ANC visit and institutional delivery all has decreased during the same period. Encouragingly, institutional delivery has remained higher for last three years than the NDHS, 2011 findings for national-39%.

Antenatal Care:

Antenatal care services include at least four focused antenatal checkup (first at 4th month, second at 6th month, third at 8th month and fourth at 9th month of pregnancy), monitor blood pressure, weight & fetal heart rate, provide health education on danger signs & care during pregnancy, delivery & postnatal period including immediate newborn care, birth preparedness & complication readiness for both normal and obstetric emergencies (delivery by skilled attendants, money, transportation & blood), early detection and management of complications as well as provision of TT immunization, iron tablets supplementation, deworming to all pregnant mothers along with providing malaria prophylaxis where necessary.
As shown in Table 9 (below), the regional average of 1st antenatal visit as % of expected pregnancy that is increased of 9% in FY 071/072 (100%) compared to past fiscal year (91%). Ilam, Dhankuta, S.Sava, Bhojpur, Solu, Khotang and Saptari has improving trend of 1st antenatal visit for the last three consecutive years, significant increase was seen in S.Sava, Khotang and Saptari in this fiscal year compared to fiscal year 070/071. Saptari has the highest (121%) whereas Illam had the lowest (71%) 1st antenatal visit in the reporting FY.
The regional average of 4th antenatal visit as % of 1st visit had decreased by 8 % in the last FY as compared to the previous FY. It has increased in Morang & Saptari; decreased in Taplejung, Terhathum, Bhojpur, Udayapur & Siraha where as fluctuating in the remaining districts in the last FY 071/072 as compared to the previous FY 070/071. It was lowest in Bhojpur (34%) and highest in Saptari (79%) in the last FY.

Delivery Care:

Delivery services include provision of skilled attendants at deliveries (either home or facility based), early detection of complicated cases and referral after providing obstetric first-aid by the health workers to appropriate health facilities where 24 hours emergency obstetric services are available. Provision of obstetric first-aid at home and/or HP/SHP if complications occur, using Emergency Obstetric Care kit (EOC kit), identification and management of complications during delivery and referral to appropriate health institutions as & when required as well as encourage registration of births & maternal & newborn deaths.
In addition, Table 9 shows that there has been fluctuating trend of deliveries at the region assisted by the Skilled Birth Attendants (as percentage of expected live births) for the last three consecutive years (47% in 069/070, 52% in 070/071 to 48% in 070/071). The trend has decreased in Sunsari; increased in Panchthar, Ilam, Jhapa, Morang, Udayapur where as fluctuating in the remaining districts in the last FY 071/072 as compared to last FY. Dhankuta has lowest (17%) and Morang had highest (87%) delivery assisted by the Skilled Birth Attendants in the last FY 071/072. A dramatic decrease (from 69% to 30%) has been reported by Sunsari which on inquiry has been suggested as case of incomplete reporting as data from BPKIHS has not been retrieved.

Further, the percentage of institutional delivery (among expected live births) at the region has also been decreasing in trend for the last three consecutive years (51% in 2069/70, 51% in 2070/071 and 49% in 071/072). Increasing trend has been observed in Taplejung, Panchthar, Jhapa, Morang, Dhankuta, Bhojpur, Sankhuwasava & Udayapur where as either fluctuating or decreased in the remaining districts.. The percentage of institutional delivery is lowest in Dhankuta (17%) and highest in Morang (87%) in the last FY.

Table 9: Key indicators for Safe Motherhood Programme by districts, FY 2069/070 to 071/072

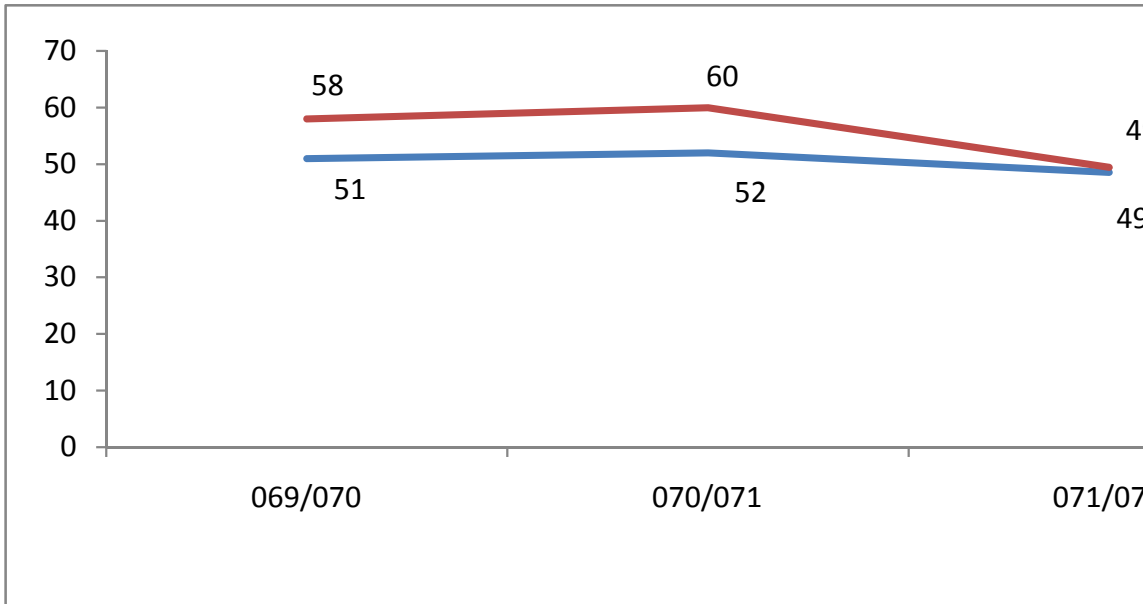
SN	Indicators	Year	Taplejung	Panchthar	Ilam	Jhapa	Morang	Sunsari	Dhankuta	Terhathum	Sankhuwasaha	Bhojpur	Solukhumbu	Okhaldhunga	Khotang	Udaypur	Saptari	Siraha	Region
1	ANC 1st visit as % of EP	069/070	70	81	59	105	100	92	73	76	76	63	87	68	90	73	100	104	**91**
		070/071	87	88	63	111	96	72	73	84	80	68	104	67	94	87	108	100	**91**
		071/072	72	78	71	110	127	79	92	83	90	75	110	74	100	85	121	94	**100**
2	ANC 4th Visit as % of ANC 1st Visits	069/070	60	48	70	48	45	44	67	53	49	46	61	66	60	57	69	57	**53**
		070/071	56	58	73	45	50	59	75	51	56	46	67	72	62	56	73	55	**57**
		071/072	43	51	43	51	50	45	49	35	50	34	55	41	53	46	79	40	**50**
3	Delivery Conducted by SBAs as % of ELB	069/070	15	33	19	56	57	69	15	22	37	14	31	44	20	29	47	57	**47**
		070/071	24	42	24	69	79	39	18	30	53	19	33	52	19	41	58	57	**52**
		071/072	21	48	24	69	87	30	17	25	52	18	28	44	18	44	35	50	**49**
4	% of Institutional Delivery Among ELB	069/070	17	36	20	61	64	76	16	24	41	18	25	42	26	33	51	58	**51**
		070/071	22	42	24	66	78	39	17	31	53	24	25	52	27	41	56	54	**51**
		071/072	25	48	23	69	87	29	17	26	52	25	26	46	21	45	33	50	**49**
5	PNC 1st Visit as % ELB	069/070	42	51	29	56	69	80	41	35	41	27	45	52	64	31	58	75	**58**
		070/071	50	55	28	70	79	41	32	41	52	30	48	60	56	40	68	69	**59**
		071/072	31	47	26	62	86	30	22	29	52	22	30	49	41	48	37	51	**49**

Postnatal Care:

Postnatal services include three postnatal visits (first within 24 hours of delivery, second visit on the third day and third visit on the seventh day after delivery), identification and management of mother's and newborn in complications during postnatal period & referral to appropriate health facility when required, promotion of exclusive breast feeding, postnatal vitamin A & iron supplementation for the mothers, immunization of newborns, education on nutrition and hygienic feeding practices as well as postnatal family planning counseling and services.

Table 9 shows that the regional average for first PNC visit as percentage of expected live births has fluctuated in the last FY 071/072 as compared to the previous FY 070/071. The figures has drastically decreased in Sunsari From from 80% to 30%, decreased in Ilam from 29% to 26%, Dhankuta from 41% to 22%, Khotang from 64% to 41 and Sirha from 75% to 51% compared to last three years. The first PNC visit is lowest in Dhankuta & Bhojpur (22%) and highest in Morang (86%) in the last FY.

Figure 8: Institutional Delivery vs. PNC 1st Visit, FY 2069/70- 071/72



As shown in Figure 8, the gap between the regional trend of first PNC visit and institutional delivery seems to be 7-8 % for last two FYs, owing to the decrease in both in PNC first visits (by 11%) as percentage of expected live births and percentage of institutional delivery (3%) among expected live births. The postnatal care provided by the health workers for home delivery cases and PNC visits are to institutional deliveries reducing no more gap.

Emergency Obstetric Care:

Basic Emergency Obstetric Care (BEOC) includes management of pregnancy complications by assisted vaginal delivery (vacuum or forceps), manual removal of placenta (MRP), manual vacuum aspiration (MVA-removal of retained products of abortion) and administration of parental drugs (for postpartum haemorrhage, infections and pre-eclampsia/eclampsia), newborn resuscitation and referral. Comprehensive Emergency Obstetric Care (CEOC) Covers surgery (caesarean section), anesthesia and 24 hours blood transfusion services along with BEOC functions.

Figure 9: Caesarian section (CS) rate, FY 2069/070- 071/072

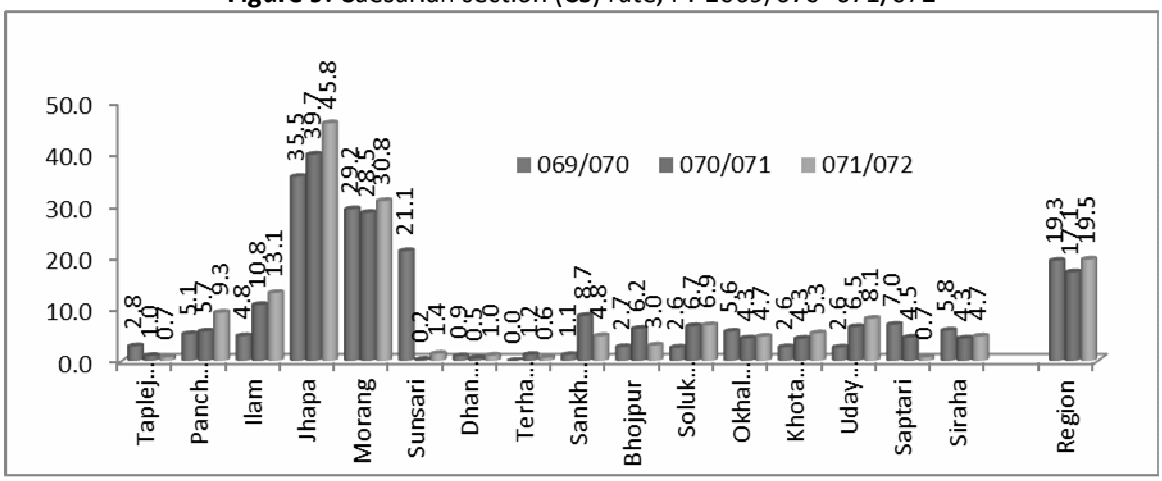


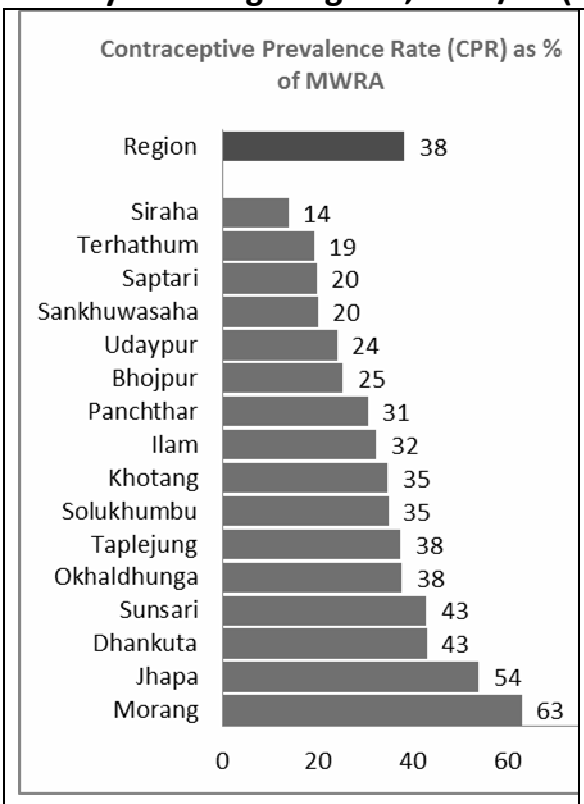
Figure 9, shows that the C-section rate in the region has a fluctuating trend. It has decreased from 19.3 percent (069/070) to 17.1 percent in fiscal year 070/071 and increased to 19.5 to past FY. The C-section rate was recorded highest in Jhapa (45.8%) followed by Morang (30.8%

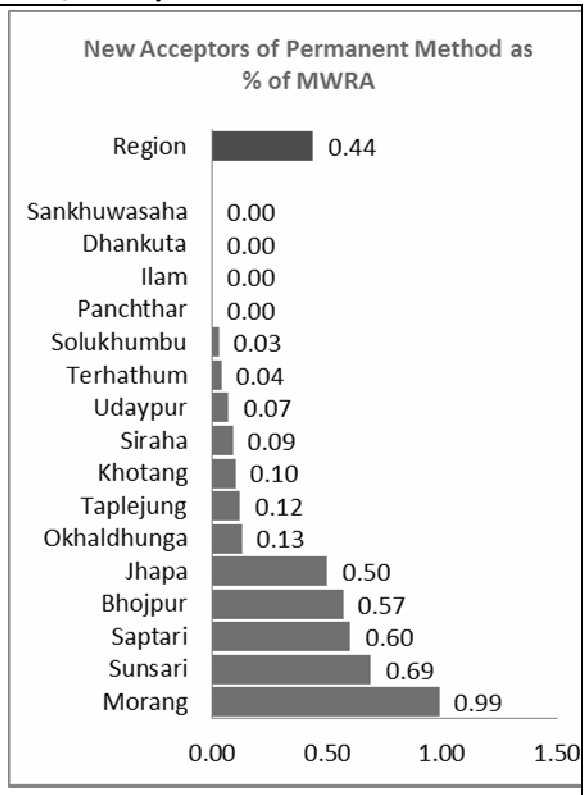
percent). It indicates that C-section rate was higher in Terai districts where there are more private hospitals and nursing homes. The possible reasons behind the high C-section rate in the region could be due to tradition of private practice of clinicians, lack of time of CEOC providers (MDGP, Gynecologists) and incentive issues.

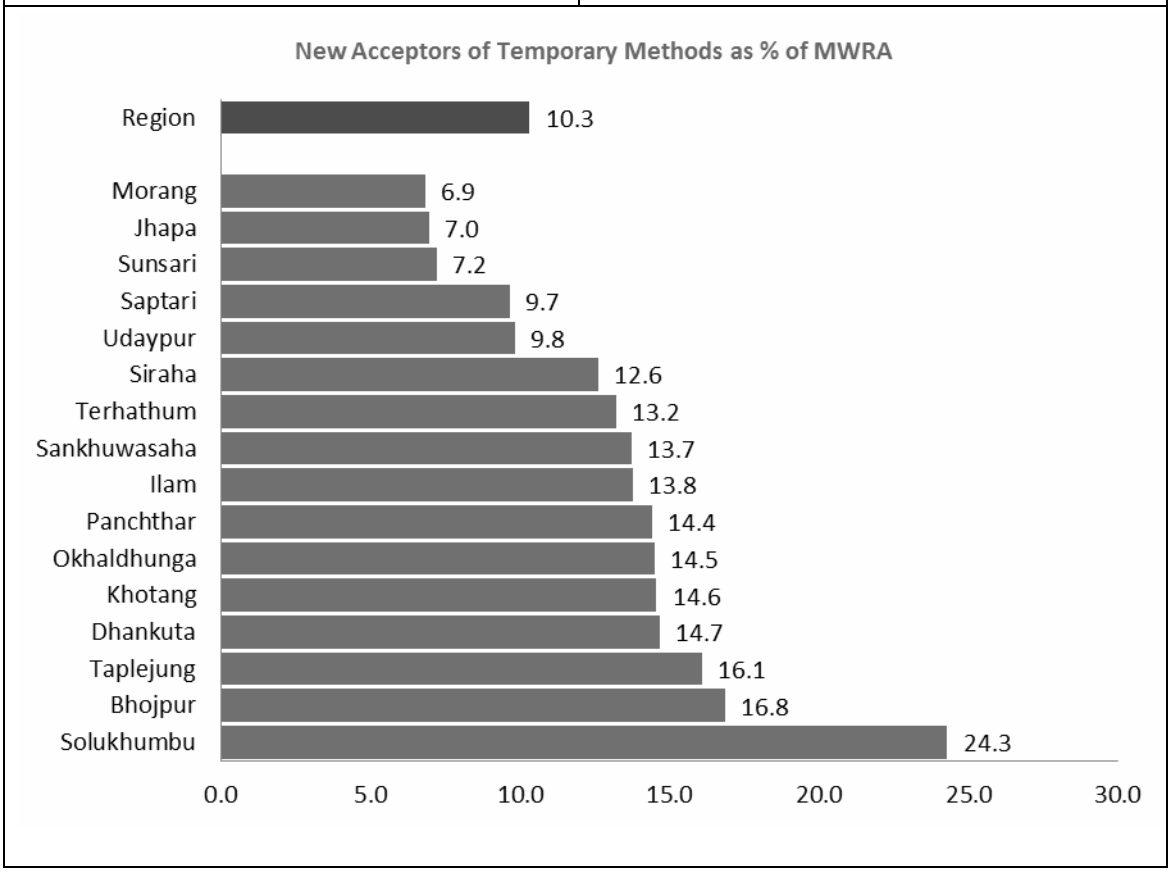
3.1.4 Issues, problems, constraints and actions to be taken

Major Achievement	Performance Gap	Causes/Reasons	Recommended actions for improvements
ANC first visit at any time reached 100 percent.	High gap between PNC and institutional deliveries	Inadequate quality service from birthing centres	Strict follow up of protocol to Increase quality service from Birthing centre
CEONC sites has been increasing in the region	Interruption of services due to contracted system for ANMs, SNs, anesthetic assistants and CEOC providers	Unscientific hiring system of human resource in contract	Provision of multiyear contract system Explore for VDC grant, provision of matching fund to initiate locally hiring system
Declaration of Zero home delivery VDC has been initiated in few districts in the region	Vacant positions of key health staff (ANMs, SNs & doctors)- Rendering 24 hours delivery services is difficult	Unmatched system of upgrading of HI and HR situation	Identify HR situation of the district (Update HR profile) and provide at least 3 SBAs and share with the center authority for initiating recruitment process
	Monitoring of private institutions is less effective (increased trend of complications and CS)	Inadequate monitoring and supervision	Intensive monitoring of the private institutions Joint monitoring plan and visit

Family Planning Program, 2070/71 (2013/2014)







3.2 FAMILY PLANNING PROGRAM

3.2.1 Background

The Family Planning (FP) Program in the region is guided by the nation policies, programmes and strategies. It is currently a priority program of the government. Family planning information and services are provided both by the public and private sectors in the region. The public sector delivers family planning services through different layers of health facilities (hospitals, PHCCs, HPs, SHPs) including PHC outlets and mobile VSC camps. The programme aims to expand and sustain adequate quality family planning services to communities through the various health service networks within the region.

Further, the aim of family planning programme is to enable couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so to ensure informed choices and make available a full range of safe and effective methods. At the community level, there are 10,876 FCHVs working across the region and they act as a bridge between the government health services and community and they are the frontline local health resource persons who provide family planning and maternal health information and services.

The ERHD has made efforts to collaborate with I/NGOs and private sectors working within the region to accelerate family planning and reproductive health services. People have limited contraceptive choices in rural and remote areas of the region. A full range of contraceptives is yet to be attained in rural and remote areas, among poor and disadvantaged groups, adolescents and young women.

Some private sector agencies provide quality FP services in the region; however their service outlets are limited to urban areas and district level facilities. Many rural outreach health facilities do not provide IUCDs or implants because of shortage of trained health personnel, but VSC services are provided in mobile camps, so sterilization is at least accessible for people in the region though there are some limitations in the hilly and mountainous districts of the region to carry out mobile VSC camps.

Family planning programmes work best when they are part of or linked to broader reproductive health programmes that address closely related health needs and when women are fully involved in the design, provision, management and evaluation of services. The quality of family planning programmes is often directly related to the level and continuity of contraceptive use and to the growth in demand for services.

Main Objective:

To improve the health status of mothers and children and improve overall quality of life of the whole family by increasing access and utilization of quality family planning services.

Specific Objectives:

1. To increase access to and use of quality FP services which are safe, effective and acceptable to individuals and couples. Special focus will be given to increasing access to services in those places where the rural, poor, Dalit, other marginalized people and those with high unmet need live.
2. To create an enabling environment for increasing access to quality family planning services to men and women.

3. To increase demand of family planning services by implementing various behavior change communication activities.

Targets:

Periodic and long-term targets for the Family Planning Program have been established as follows:

- To reduce TFR to 2.5 children per woman by 2015
- To increase the CPR to 67 percent by 2015

3.2.2 Major Activities

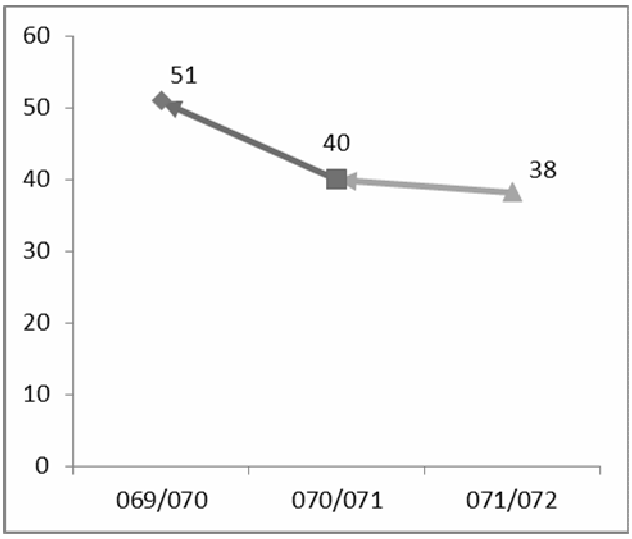
Various modern contraceptive methods are available under the national health services delivery system. The planned sets of family planning activities are almost similar in the districts; however some districts in the region might have some different FP initiatives that suit their context and mostly supported by the NGOs sectors.

The major activities implemented during FY 2071/72 are briefly described below.

- IUCD and Implant sites were expanded in various layers of health facilities with special emphasis on thorough counseling and follow-up services.
- Carried out regular monitoring & supervision of family planning activities and on site coaching to the SBA trained nursing staff.
- Conducted IUCD refresher training to SBA trained nursing staff
- Organized satellite clinics in hard to reach areas for long spacing family planning methods.
- Conducted mobile VSC outreach services as per given targets to the districts.
- Free access to condom by having condom boxes at all health institutions and resupplying pills and distributing condom through FCHVs.
- Provided non-clinical methods (condoms, pills, and injectable) through static and outreach services.
- Ensured availability of family planning services through a combination of static, outreach and referral services.
- Conducted review of reproductive health including family planning programmes.
- Purchased and distribution of IUCD and Implant insertion and removal kits.
- Coordinated with non-governmental organizations and private sectors for conducting mobile FP services.
- Distribution of oral pills and condoms were made through FCHVs at the community level.
- Family planning counseling services are provided to potential clients by front line FP providers.

3.2.3 Analysis of Achievement:

Figure 10: Contraceptive Prevalence Rate (CPR), FY 2069/070-071/72



As shown in Figure 10, the CPR of the region has decreased by 2% in this FY 071/72 as compared to last FY 070/071. This figure which was greater than the regional average of NDHS, 2011 (46.4%) has slipped to only 38% which is also less than national figure of 49.7% (NDHS, 2011).

It seems that eastern region is still far behind to meet the figures as targeted by NHSP-II (67 percent by 2015). The high level of out-migration of youth could have contributed to the lower contraceptive prevalence rate in the region.

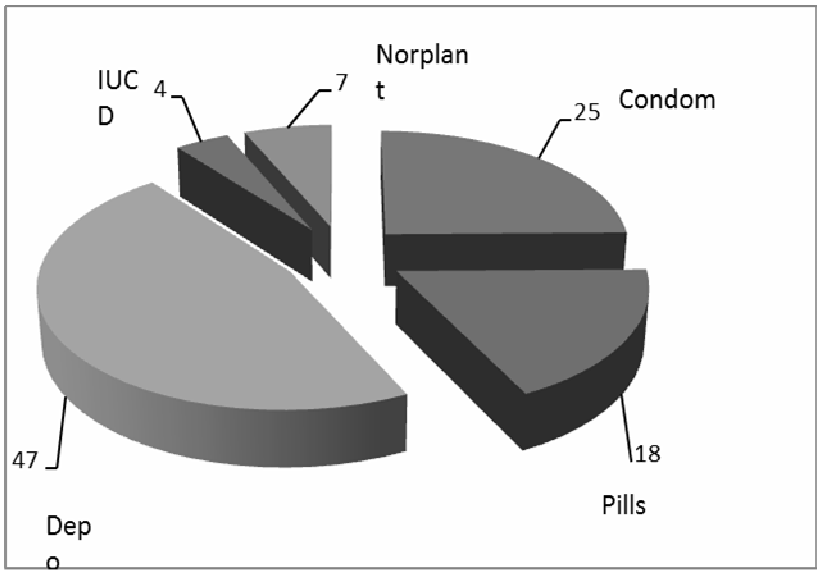


Figure 11: FP new acceptors of spacing methods, FY 2071/072

As shown in Figure 11, Depo-Provera is the most common choice (47%) of spacing contraceptives method in the region in this FY 2071/72 followed by condom (25%). There is a need to prepare FP commodities projection on regular basis at districts accordingly to ensure no stock out of any FP commodities.

The CPR is one of the main indicators for monitoring and evaluating the National Family Planning Program. As shown in Table 12 (below), the CPR of the region has decreased as compared to last two FYs. The CPR of the Eastern Region is 38% in this FY 071/072.

Considering the current CPR status of the region, there is still the challenge to achieve the national target (67%) by 2015. However, the region has achieved the target of TFR 2.5 as per the findings of NDHS, 2011 for eastern region. Further, while CPR for many districts have minor fluctuations, the CPR of some districts such as Panchthar, Ilam, Dhankuta, Terhathum Sankhuwasava, Bhojpur, Solu and Saptari has decreased. The CPR is highest (63%) in Morang and lowest (14%) in Siraha district.

Table 12: District wise indicators of Family Planning FY 2069/70 – 071/72

SN	Indicators	Year	Taplejung	Panchthar	Ilam	Jhapa	Morang	Sunsari	Dhankuta	Terhathum	Sankhuwasaba	Bhojpur	Solukhumbu	Okhaldhunga	Khotang	Udaypur	Saptari	Siraha	**Region**
1	Contraceptive Prevalence Rate (CPR) as % of MWRA	069/070	24	35	55	54	65	43	48	33	30	29	46	42	38	29	62	59	**51**
		070/071	19	34	51	54	63	41	46	21	30	26	44	24	45	14	24	14	**40**
		071/072	38	31	32	54	63	43	43	19	20	25	35	38	35	24	20	14	**38**
2	New Acceptors, Method Mix as % of MWRA	069/070	10.5	13	11.3	11.9	10.1	8.5	18.5	14.2	14.1	8.9	25.1	15.8	10.9	22.2	12.4	9.4	**11.9**
		070/071	15.6	13.6	10.4	9.9	8.2	9.1	12.2	14	14.5	14.7	24.2	15.9	11.5	10.4	13	8.8	**10.8**
		071/072	16.4	14.4	13.8	7.5	51.1	62.3	14.7	8.0	2.6	3.1	24.3	11.5	8.3	22.3	10.2	12.7	**10.8**
4	New Acceptors as % of MWRA (Total Spacing Method)	069/070	10.5	12.9	11.3	10.2	8.9	7.5	18.4	14.1	14.1	8.4	25	15.3	10.7	8.7	10.5	9	**10.3**
		070/071	15.5	13.6	10.4	8.1	7.1	8.2	12.2	14	14.4	14.6	24.2	15.7	11.4	10.4	13	8.7	**10.2**
		071/072	16.3	14.4	13.8	7.0	44.7	56.8	14.7	8.0	2.6	3.0	24.3	11.3	8.3	22.1	9.6	12.6	**10.3**

Similarly, the percentage of new acceptors (method mix as % of MWRA) in the region has slightly decreased and stagnant in FY 070/071 & 071/072. Most of the districts show a fluctuating trend for the new acceptors (method mix as % of MWRA) in the last three consecutive FYs but has increased in Taplejung, Panchtahr, drastically in Sunsari, Solu and Udayapur in the FY FY 071/072.The highest percentage of new acceptors- method mix as % of MWRA (62.3%) was reported in Sunsari and lowest in in Solukhumbu district (2.6%).

Moreover, new acceptors (total spacing method as % of MWRA) has increased drastically in Taplejung, Panchtahr, Sunsari, Solu and Udayapur in the FY FY 071/072.The highest percentage of new acceptors- method mix as % of MWRA (56.8%) was reported in Sunsari and lowest in in Solukhumbu district (2.6%).Table 12 further indicates that new acceptors (total spacing method as % of MWRA) at regional level has not changed significantly over the last two years' period although higher than the FY 070/071.

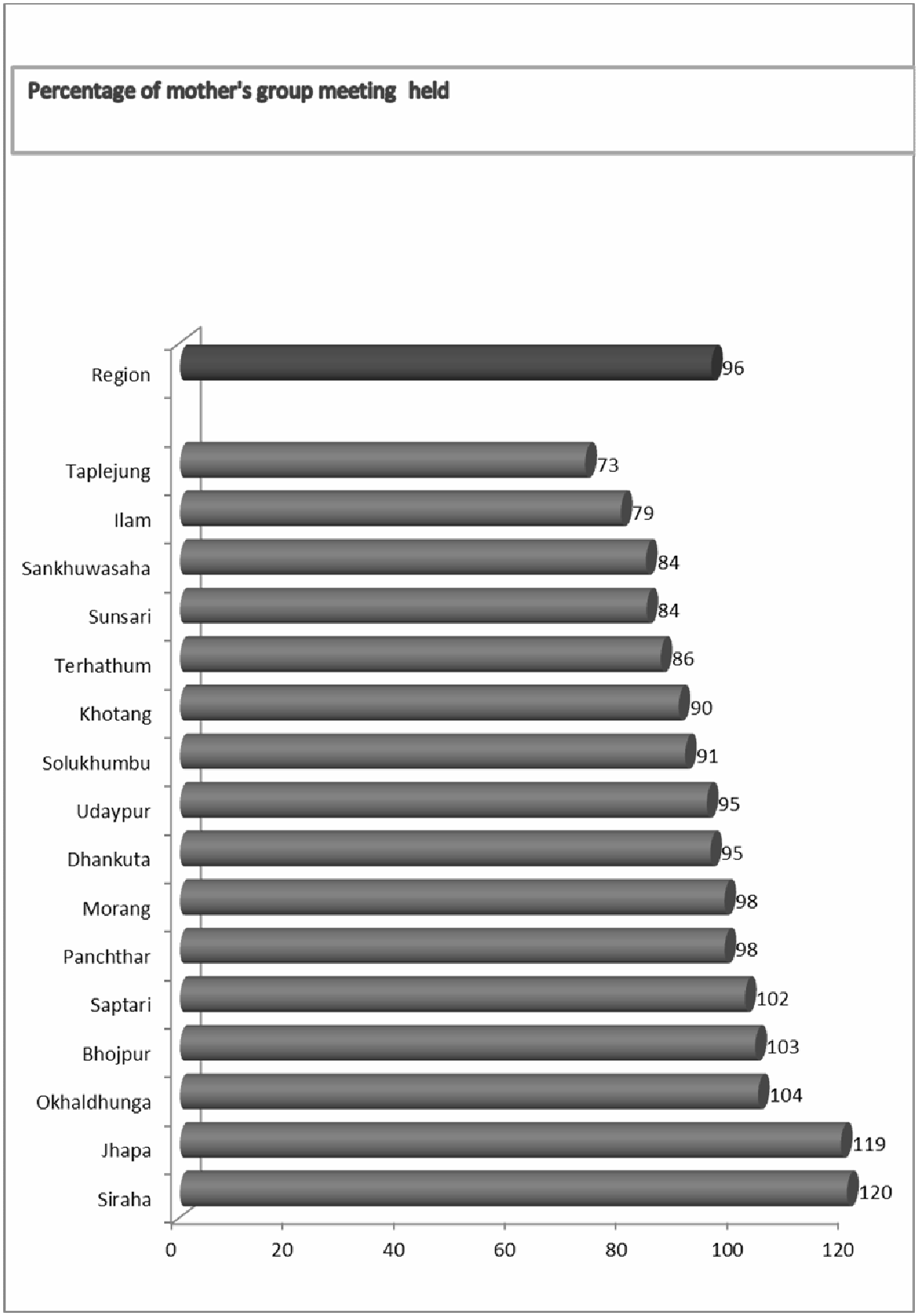
3.2.4 Issues, problem, constraints and actions to be taken

Major Achievement	performance Gap	Causes/Reasons	Recommended actions for improvements
Greater participation on FP by NGO and private sector	Low CPR	male migration, private sector not reporting	Strengthen private sector reporting into HMIS
	Postpartum mothers are not adequately captured by FP programme	Inadequate training	Health workers need to be trained on postpartum FP counseling
	SBAs deployed in birthing centers are not fully competent for providing long spacing FP services, affects expansion of IUCD and Implant sites	Inadequate knowledge and skills about long acting methods	Include in MNH clinical update training, if possible or on site coaching & mentoring On the job provision at district hospitals

Conclusion

The CPR of the region is has decreased in this FY as compared to previous FYs, it needs to be improved to meet the NHSP target of 67% by 2015. NGOs contribution for family planning in the hilly areas needs to be strengthened. The achievement on VSC shows satisfactory results. However, new acceptors in all modern spacing conceptive methods have slightly decreased in the region. The common choice of spacing contraceptive method was Depo-Provera.

FCHV Programme, 2071/72 (2014/2015)



3.3 FCHV PROGRAM

3.3.1 Background

The FCHVs act as a bridge between the government health services and community. They are the foundation of Nepal's community-based primary health care system and have made significant contributions to women's leadership and empowerment at the VDC level. Additionally, FCHVs play an important role in contributing to a variety of key public health programs, including family planning, maternal & newborn care, vitamin A supplementation/ de worming and immunization coverage. There are a total of 10,876 FCHVs working across the eastern region. The overall FCHVs programmes in the region is guided by the national policy and strategies i.e. revised FCHVs programme strategy (2010) which provides strategic directions and critical approaches to ensure a strengthened regional and national program.

They are the frontline health resources who are supposed to provide necessary information and services on health and healthy behavior of mothers and community people for the promotion of safe motherhood, child health, family planning, and other community based health services with the support of the trained health workers working at the below district level health facilities. FCHVs are selected by the Mothers Group for health in each ward with the support from other community leaders. They are provided training on basic primary health components.

The role of the FCHVs has been outlined as below-

- To act as voluntary health educators and promoters, community mobilizers, referral agents and community-based service providers in areas of health as per the trainings received.
- To promote the utilization of available health services and the adoption of preventive health practices among community members.
- To play a supportive role in linking the community with available PHC services and to continue to play an important role related to family planning, maternal/neonatal health, child health and selected infectious diseases at the community level.

  The goal of FCHV program is to support the national goal of health through community involvement in public health activities.

Objectives of FCHVs program

FCHV program has the following objectives:

- To activate the women for tackling common health problems by imparting relevant knowledge and skills
- To prepare a pool of self-motivated volunteers as a focal person to bridge health programs with community
- To increase the community participation in improving health
- To develop FCHV as a motivator for health
- To increase utilization of health care services through demand creation

3.3.2 Major Activities

The major activities carried out under the FCHVs programme are mostly identical in all districts within the region. The following major activities were undertaken under the FCHVs programme during the reporting period:

- Celebration of FCHVs day
- Conducted FCHVs fund utilization training to VDC level fund management committee members in the selected districts.
- Provided reward for voluntary retirement.

- Conducted Health Mothers Group meetings & its revitalization programme.
- Mobilization of FCHVs in national campaigns- Vitamin A, de-worming, polio and newborn care including Chlorhexidine Navi Care Programme etc
- Dress allowance distributed to all FCHVs.
- Establishment of FCHV fund.

3.3.3 Analysis of Achievement

Figure 13: Percentage of mothers' group meeting conduction, FY 2069/70 - 071/72

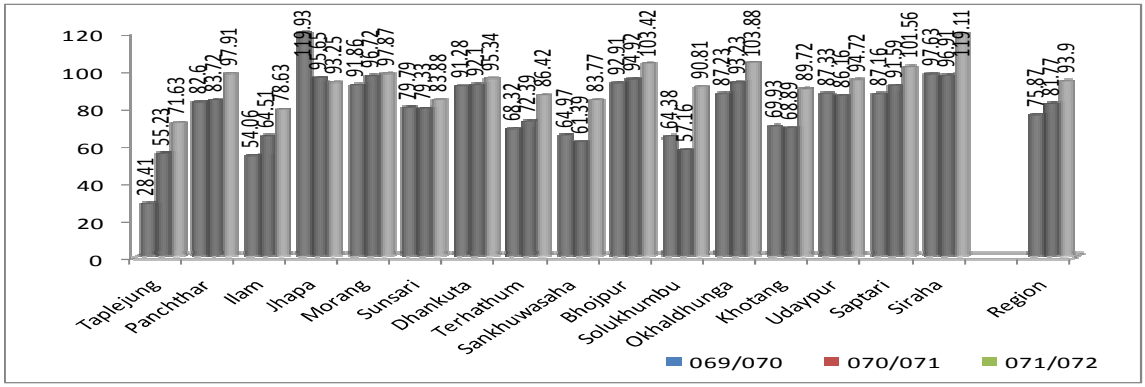
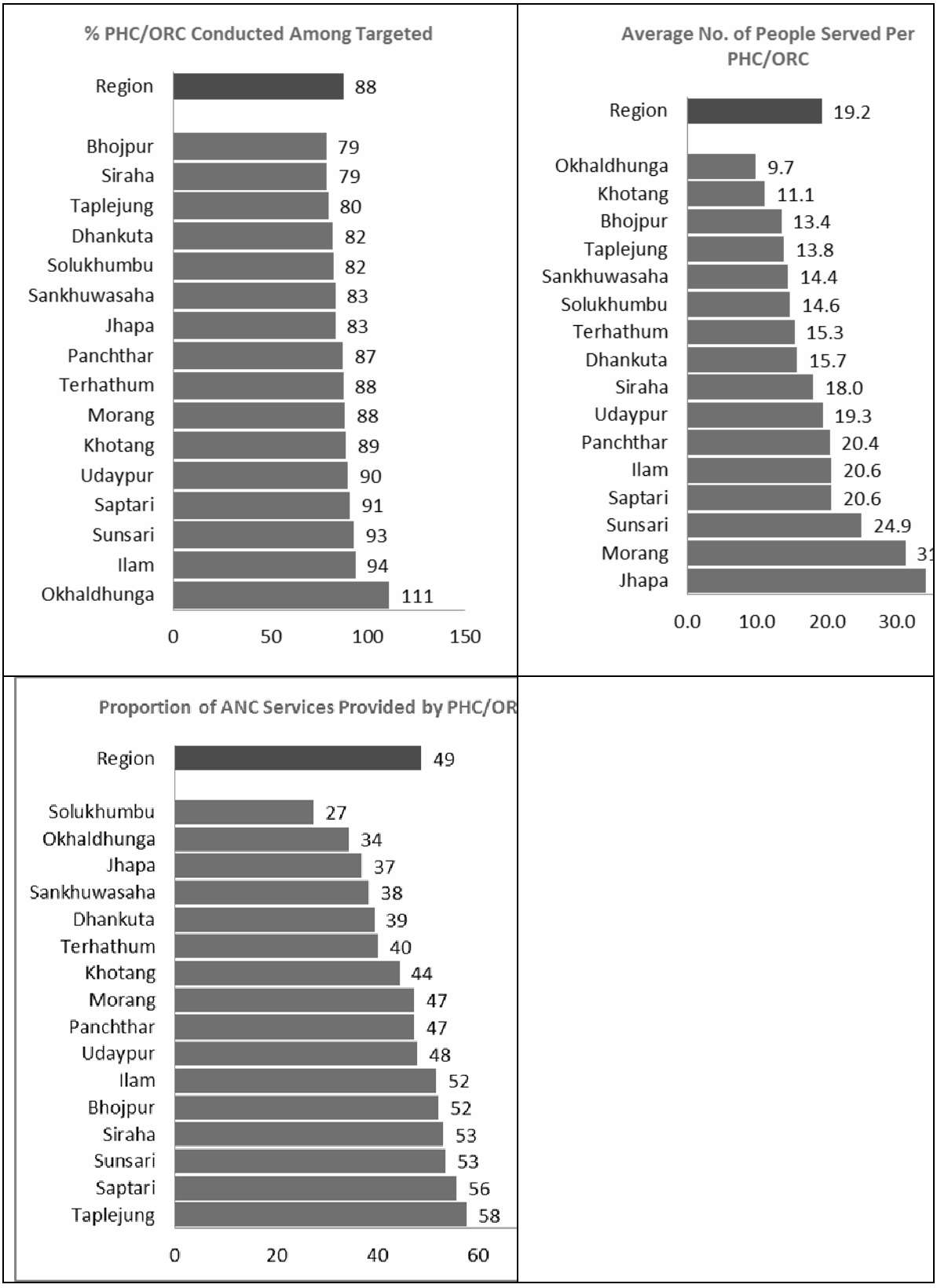


Figure 13 shows the progress achieved by each district within the region on mothers' group meeting conduction. It is observed that there is fluctuating trend of mothers' group meeting conduction at the region. It had decreased from 76% in FY 2069/70 to 82 % in FY 2070/71 which increased to 94 % in FY 2071/72. Decline in mothers' group meeting conduction was seen in one districts of the region, viz. Jhapa whereas increasing trend was observed in other 15 districts, which contributed to increment in the region's trend during FY 2071/72 compared to previous FY 2070/71. The percentage of mothers' group meeting conduction is highest in Siraha (119 %) and lowest in Taplejung (72%).

3.3.4 Issues/problems, constraints and action to be taken

Major Achievement	Performance Gap	Causes/Reason	Recommended actions for improvements
Percentage of Mother's group meeting held is in increasing trend	Low performance from old, illiterate FCHVs. Retirement of FCHVs is not executed mandatorily as per age bar limitation	lack of appropriate exit mechanism	Needs policy revision –provision of mandatory retirement policy with limited age bar
	Mothers' group meeting are not conducted on regular basis in some districts	inadequate incentive and encouragemen t	Needs policy revision-Health mothers group meetings need to carry out on every alternate month and provision of incentives for meeting Explore for provision of VDC grant, linking with Saving and Credit activities- needs coordination between MoHP and MoLD
	Transportation allowance of FCHVs is not adequate	Inadequate allowance	Transportation allowance for FCHVs need to be revised in accordance to the market inflation

PHC-ORC Programme, 2071/072 (2014/2015)



3.4 PRIMARY HEALTH CARE OUTREACH PROGRAM

3.4.1 Background

As envisaged in the national health policy 1991, health facilities were extended up to village level. However, utilization of services provided by health facilities, especially preventive and promotive services, has been found to be limited because of limited accessibility. Thus, it was felt that services should be closer to the community.

Considering this, PHC/ORC services was initiated and established in 1994 (2051 BS) primarily with an aim to improve access to some basic health services including family planning and safe motherhood services for rural households. PHC/ORC clinics are the extension of PHCCs, HPs and SHPs at the community level.

VHWs and MCHWs or ANMs/AHWs provide basic PHC services (FP and ANC services/Health Education/ Minor Treatment) to a pre-arranged place close to communities on a predetermined day once in a month. The clinics are held at locations not more than half an hour's walking distance for the population residing in that area. According to PHC/ORC strategy, following services are provided by PHC/ORC:

- Safe motherhood (ANC,PNC, newborn care & referral)
- Child health (Growth monitoring of <5 children, treatment of pneumonia and diarrhea)
- Family Planning (distribution of pills, depo-provera & condoms, monitoring of continuous users, defaulter tracing, education& counseling on FP methods, counseling & referral for long acting spacing methods & VSC)
- Health education & counseling (maternal and newborn care, child health issues, family planning)
- Adolescents' reproductive health
- First-aid treatment

3.4.2 Major Activities

The major activities under PHC/ORC programme carried out in the districts are mostly similar. The selected dysfunctional PHC/ORCs in the districts were reactivated and reorganized in this fiscal year with the initiation of district leadership. The following activities were carried out under this section during the reporting period:

- Purchased and supplied PHC/ORC kits with recommended equipment and drugs.
- Reactivated and re-organized the dysfunctional PHC/ORCs to provide access to disadvantaged groups.
- Conducted PHC/ORC reactivation and micro planning orientation.
- Regular conduction of predetermined PHC Outreach clinics.
- Conducted regular supervision and monitoring of PHC Outreach clinics.
- Carried out community mobilization activities for PHC/ORC programme.

3.4.3 Analysis of Achievement

Figure 14: Percentage of PHC/ORC conducted, FY 2069/070-071/72

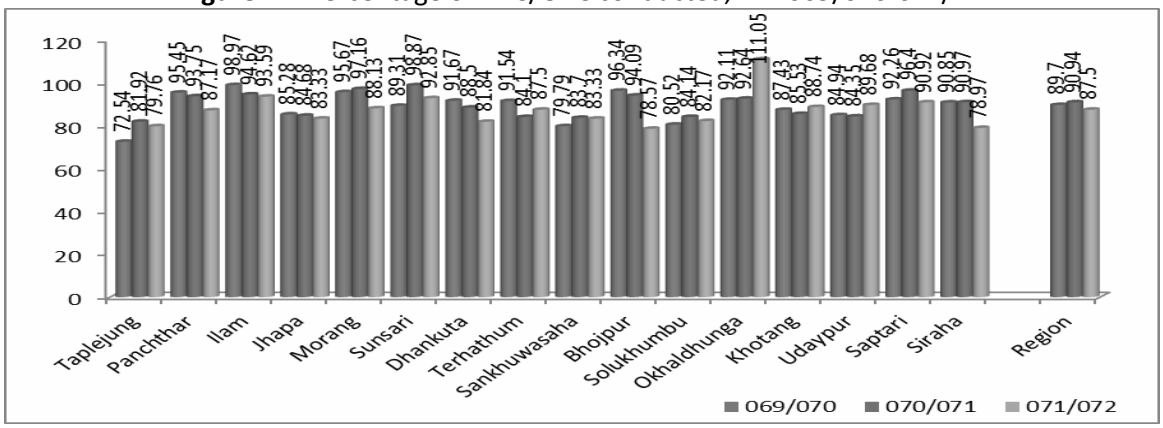


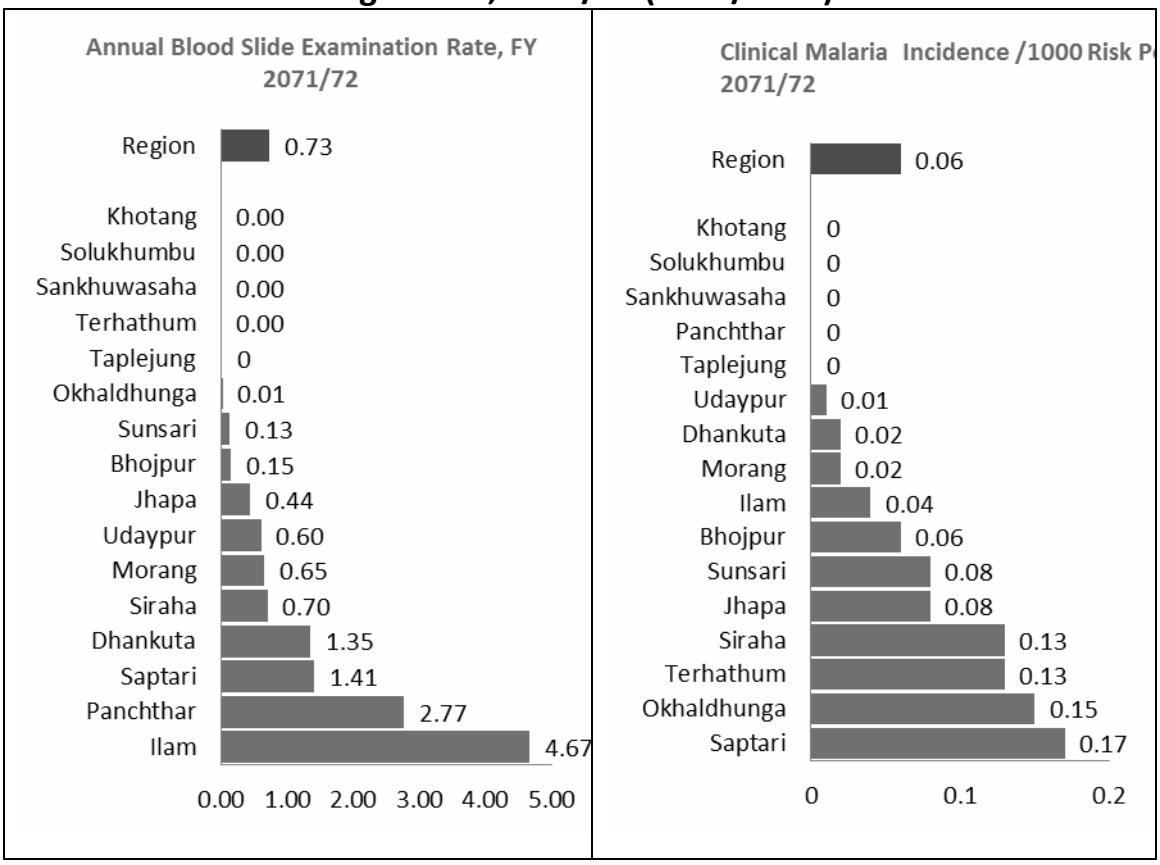
Figure 14 indicates that there is slight rise in percentage of PHC/ORC conducted against targeted at the region in during FY 071/072 as compared to the previous FYs. Increasing trend has been seen in Terhathum, Udayapur in FY 071/072 compared to FY 070/071 whereas in rest of the districts, the PHC/ORC conducted against targeted has decreased this year in comparison with the last fiscal year.

3.4.4 Issues/problems, constraints and action to be taken

Major Achievement	Performance Gap	Causes/Reasons	Recommended actions for improvements
Rise in PHC/ORC conducted against target	No increment of the PHC/ORC service utilization	Inadequate capacity enhancement programs	PHC/ORC Management Committee need to be reactivated by capacity building and provision of necessary resources
	Inadequate infrastructure of PHC/ORC	Inadequate Budget	Provision of basic infrastructure and furniture for PHC/ORC

4 DISEASE CONTROL

5 Malaria Control Programme, 2071/72 (2014/2015)



4.1 MALARIA

4.1.1 Background

Malaria eradication program was started in the year of 1962 in this region and was continued up to the year 1977. But since the year of 1978 eradication program was eventually reverted to Malaria Control Program as recommended by WHO. At present, this program is carried out in all districts within the region except in Solukhumbu district. The high risk of getting this disease is attributed to the abundance of vector mosquitoes, mobile and vulnerable population, relative inaccessibility of the area, suitable temperature, environmental and socio-economic factors. Currently, malaria control activities are carried out in 15 districts in the region at risk of malaria. The Global Fund is supporting malaria control program in the high and moderate risk districts.

Objectives of Malaria Control Program:

1: To enhance strategic information for decision making towards malaria elimination.
2: To further reduce malaria transmission and eliminate the foci.
3: To improve quality of and access to early diagnosis and effective treatment of malaria.
4: To sustain support from the political leadership and the communities towards malaria elimination.

4.1.2 Major Activities

The major activities under malaria control programme carried out in the districts were mostly similar. The following malaria control activities were conducted during the reporting period:

- Spraying at high risk and outbreak prone areas
- Review of malaria control program.
- Case detection and treatment
- Prevention and control measures
- Epidemic prevention and control
- IEC and BCC activities

4.1.3 Analysis of achievements

Table 13: Malariometric Indicators

Fiscal Year	Total Slide Examined (RDT+MC)	Total Positive (RDT+MC)	ABSCR %	ABER %	SPR %	API /1000	IMP %	PF %	CMI
2069/70	28113	249	73	0.68	0.89	0.06	34.4	1.05	2.71
2070/71	24185	256	59	0.86	1.06	0.07	33.33	0.81	2.35
2071/72	17658	203	66	0.73	1.24	0.06	37.99	0.01	NA

Table 13 indicates that the number of laboratory confirmed malaria cases has decreased in FY 2071/72 as compared to FY 2070/71. A total of 17658 slides (RDT+MC) were examined and 203 positive cases (RDT+MC) were detected in the region during the reporting period. Similarly, the proportion of *Plasmodium falciparum* (PF %) cases has also decreased sharply from 0.81 percent in FY 2070/71 to 0.01 percent in the FY 2071/72. The Annual Parasite Incidence (API) rate has only slightly decreased from 0.07 in FY 2070/71 to 0.06 in FY 2071/72. Likewise, slide positivity rate (SPR) has increased this FY 2071/72 to 1.24% as compared to 1.06% in the last FY 2070/71. Annual blood slide collection rate (ABSCR) has increased in the FY 2071/72 (66%) as compared to the previous FY 2070/71 (59%).

Additionally, the Annual Blood Examination Rate (ABER) has decreased in this FY 2071/72 as compared to the last FY 2070/71, from 0.86% to 0.73%. Table 13 further reveals that the proportion of imported malaria (IMP) has increased to 38 % in FY 2071/72 as compared to 33% in FY 2070/71 and 34% in FY 2069/70 which indicates the need of continuous cross border monitoring and surveillance of malaria.

Figure 15: Slide positivity rate, FY 2069/070 to 071/72

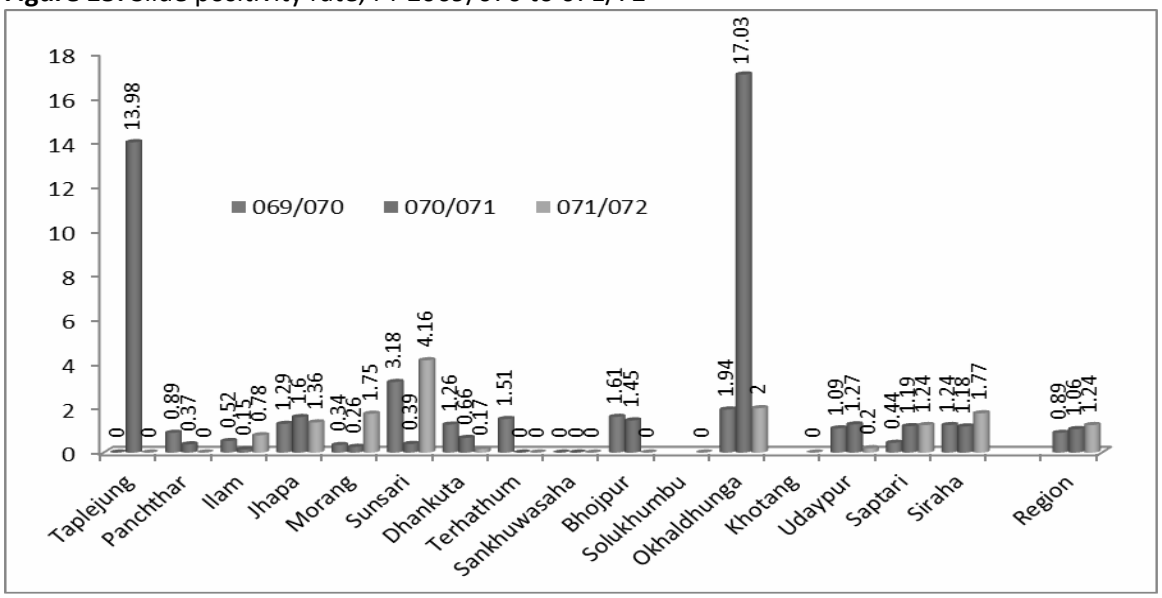
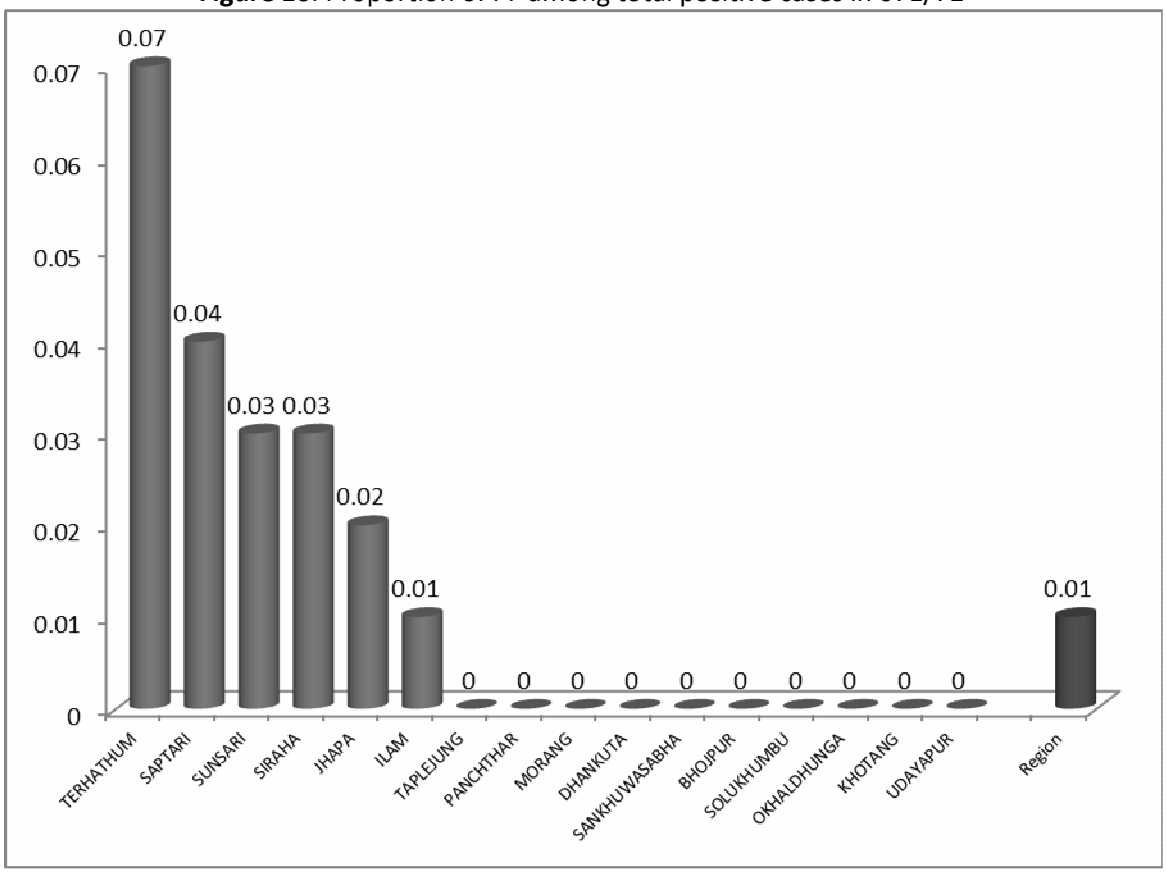


Figure 15 shows that there is increasing trend of percentage of confirmed malaria cases among slide examination in the region. Slide positivity rate has slightly increased in the last FY 2071/72 as compared to the last two FYs at regional level. Further, the trend is increasing in Morang and Saptari. Regional average of percentage of confirmed malaria cases among slide examination in FY 2071/72 is 1.24 percent with the range of 0.0 percent to 4.2 percent in Sunsari. There are no reported confirmed malaria cases in Taplejung, Panchthar, Terhathum, Sankhuwasabha, Bhojpur, Solu and Khotang districts in FY 2071/72.

Figure 16: Proportion of PF among total positive cases in 071/72



As shown in Figure 16, it is noted that proportion of Plasmodium Falciparum (PF) was 0.01 and highest was observed in Terhathum .

4.1.4 Issues, Problems, Constraints and action to be taken

Major Achievements	Performance Gap	Causes/Reasons	Recommended actions for improvement
Annual blood slide collection rate (ABSCR) has increased	Blood slide collection and examination is low in some districts	Insufficient microscopic centres and training	Need to provide malaria microscopy training to the relevant HWs
Proportion of plasmodium Falciparum has decreased sharply	Budget release mechanism is complicated and delay.	delay in budget release	Provision of simplified and timely budget release mechanism

4.2 KALA-AZAR

4.2.1 Background

Kala-azar has been reported from six districts in this region, in FY 2071/72. Moinaly Terai districts (Morang, Siraha, Sunsari, Jhapa, Saptari, and Udayapur) are highly affected districts in the region. In these endemic areas, particularly children and young adults are its principal victims. The disease is fatal if it is not timely treated. In the recent years, Kala-azar and HIV co-infections have emerged as a health problem. The recorded cases of Kala-azar indicate that mostly the rural people with low socio economic status, are vulnerable. There have been some significant advances both in the diagnosis and treatment of Kala-azar over the last decade. The rK39 dipstick test kit, a rapid and easy applicable serological test has been demonstrated to have high sensitivity and specificity in validity studies. For the first time, an oral drug- Miltefosine has proven to be efficacious in drug trials and has been registered for the use in Kala-azar.

Goal

Reduce incidence of Kala-azar to less than 1 case per 10,000 populations at district level by 2015.

Objectives

- Reducing the incidence of Kala-azar in the endemic communities including the poor, vulnerable and unreached population;
- Reducing case fatality rates from Kala-azar;
- Treatment of Post *Kala-azar* Dermal Leishmaniasis (*PKDL*) to reduce the parasite reservoir; and
- Prevention and treatment of Kala-azar HIV–TB Co infections.

4.2.2 Major Activities

Kala-azar elimination activities were carried out in Saptari district as a pilot program initiated jointly by the center & district. The major activities under Kala-azar prevention and control program (to achieve Kala-azar elimination by 2015) conducted in six endemic districts of the region during the reporting period are mostly similar which are as follows:

- Case detection and treatment,
- Indoor Residual Spraying (IRS) was carried out in prioritised Kala-azar affected areas
- Continuation of treatment through Miltefosine and Amphotericine B
- Trainings and orientations - health workers were trained on appropriate skills required for prevention and control of vector borne diseases including Kala-azar. The lab personnel from the selected hospitals were trained on rK-39 dipstick diagnosis of Kalaazar.
- Conducted IEC and BCC activities in the Kala-azar endemic districs.

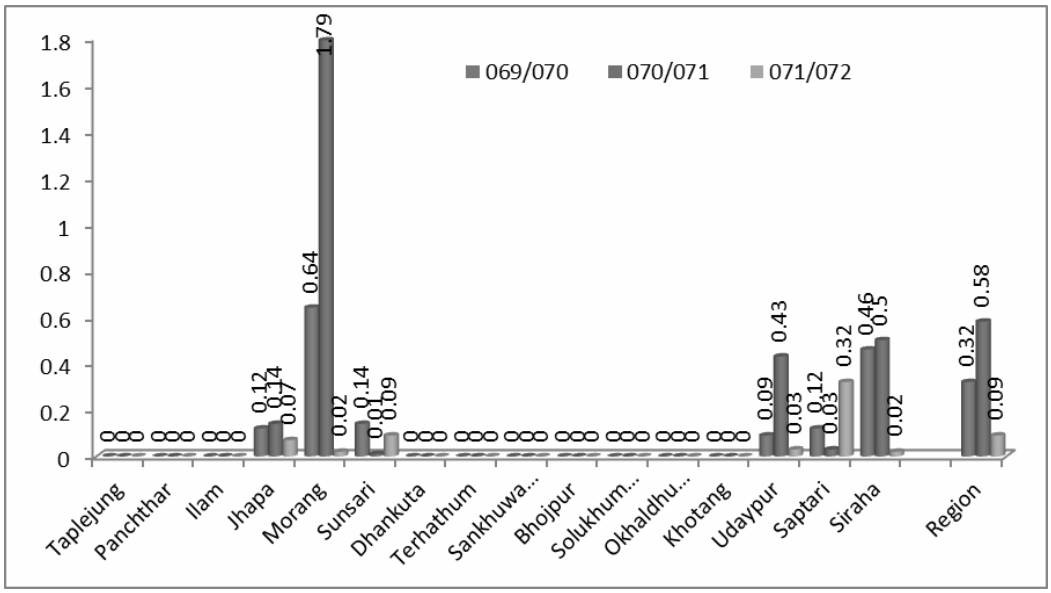
4.2.3 Analysis of achievements

Figure 17 below shows that the incidence of Kala-azar per 10,000 populations over the three years' period was fluctuating at regional level. However, it is important to note that the incidence has been showing decreasing trend, from 0.37 in FY 2069/70 to 0.58 in FY 2070/71 and 0.9 in this FY 2071/72.

Analyzing further, the trend of incidence has increased in Sunsari & Saptari with fluctuation over three years whereas fluctuating trend was observed in other districts. In

FY 2071/72, the regional average of incidence of Kala-azar is 0.09 per 10,000 population with the range of 0.0 – 0.32. The incidence was reported highest in Sunsari (0.32/10,000) and lowest in Morang & Siraha (0.02/10,000). There were two reported deaths in Jhapa and one at Udayapur.

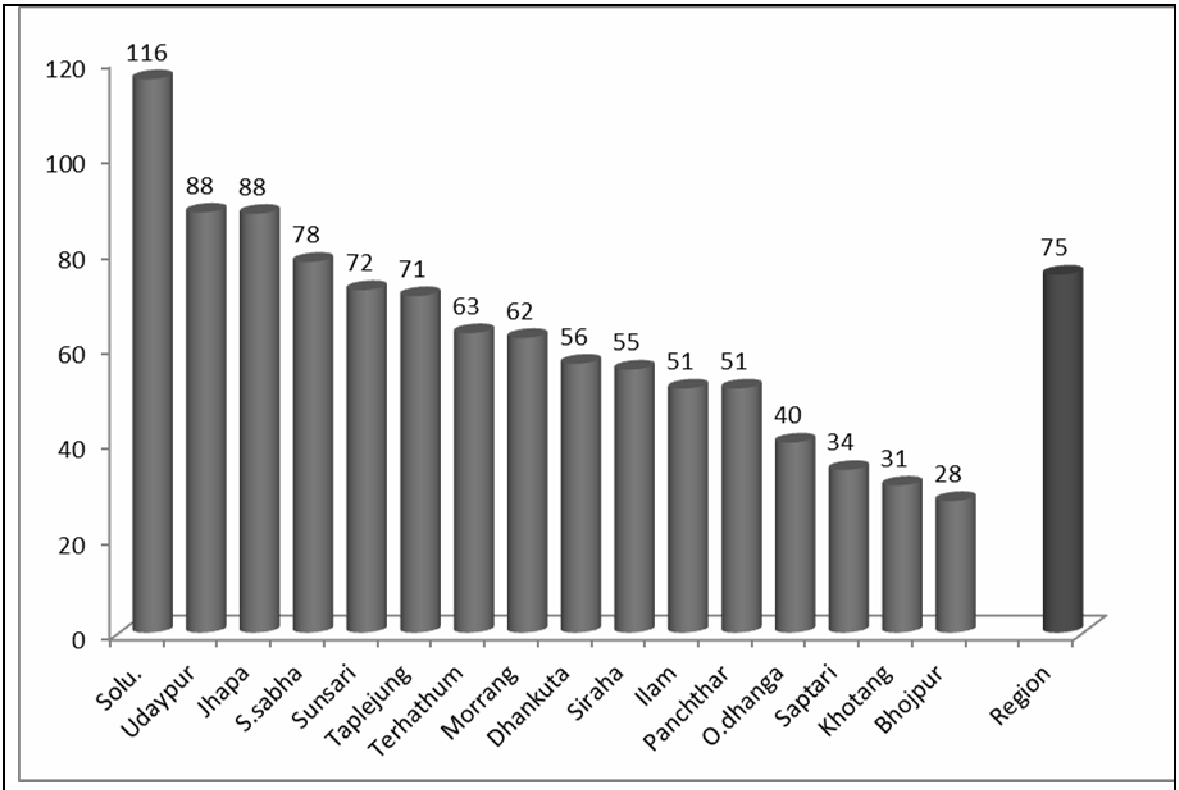
Figure 17: Incidence of Kala-azar/10,000 population, FY 2069/070-071/72

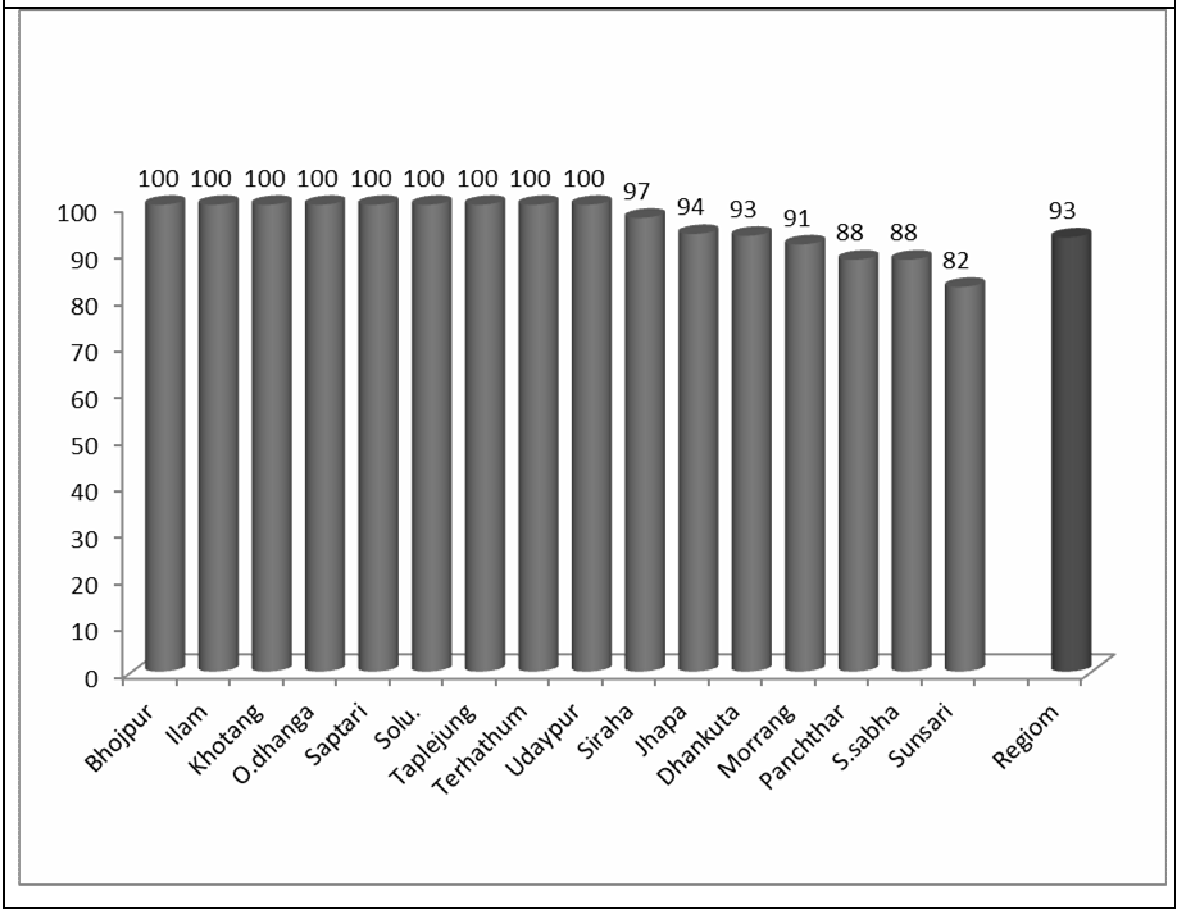


4.2.4 Issues/problems, constraints and action to be taken

Major Achievements	Performance gap	Causes/reasons	recommended actions for improvements
incidence of Kala-azar per 10,000 populations has been decreasing	There is increasing trends in some districts	Inadequate orientation to health workers. Regimen change but no training, so difficulty in treatment	Conduct training/orientations to the relevant health workers
	Difficulty in conduction of spraying (IRS)	Old and broken spraying equipment.	Make provision for repair and maintenance of spraying equipment.

Tuberculosis Control Programme, FY 2071/72 (2014/2015)





4.3 TUBERCULOSIS

4.3.1 Background

Tuberculosis (TB) is one of the major public health problems in the region. The tuberculosis control programme at the region is guided by the national policies and strategies. The region has coordinated with different public & private sectors, local government bodies, I/NGOs, social workers in order to expand DOTS, establish/reactivate DOTS Committee and increase social mobilization at various levels. A well team work has been established in the region between the public and private sectors in order to sustain the results achieved by NTP at the regional level. DOTS by community volunteers, I/NGOs and CBOs has been found effective in some hill and mountain districts of the region. Besides the government health institutions, the major partners in implementing DOTS programme in the region are private and social sectors.

The number of DOTS treatment centres has reached to 952 and 125 microscopic centers. The number of urban DOTS in the region is 49 including 3 MDR treatment centers with 16 sub-centers. The treatment success rate stands at 88 percent and case finding rate of 75 percent. At the regional level total 3491 TB patients have been identified and registered of whom 3083 (Male-2130, Female-953) are infectious (sputum smear positive new cases) and are being treated under the DOTS strategy in NTP during the FY 2071/72.

The basic unit of management for diagnosis and treatment of TB patients is the district hospitals, Primary Health Centres and selected health posts whereas other health posts acts as sub-centres for supervision of patients on DOTS. However, from this FY all sub-centres have been upgraded to treatment centres. The Regional Health Directorate provides technical and managerial support in TB control activities launched within the region including regular supervision and monitoring. All centers offering treatment for patients with tuberculosis must utilize the standardized regimens of short course chemotherapy (SCC) adopted by the NTP, with Directly Observed Treatment Short Course (DOTS).

Goal:

To reduce the mortality, morbidity and transmission of tuberculosis until it is no longer a public health problem in Nepal.

Objectives

- Achieve universal access to high-quality diagnosis and patient-centred treatment
- Reduce the human suffering and socioeconomic burden associated with TB
- Protect poor and vulnerable populations from TB, TB/HIV and multi-drug-resistant TB
- Support development of new tools and enable their timely and effective use

4.3.2 Major Activities

The major activities under Tuberculosis control program carried out in all districts of eastern region are mostly similar. The following activities were carried out under this section during the reporting period:

- Carried out quarterly review meetings
- Conducted TB coordination meetings with different stakeholders and partners.
- Celebrated World TB Day with different IEC/BCC and advocacy activities.
- Conducted public private workshops on TB.
- Carried out TB/HIV sensitization meetings.

- Conducted TB modular/refresher and lab modular/refresher training to the health workers and Lab assistants.
- Carried out review meetings for TB/HIV and drug resistance.
- Expansion of microscopic centers, DOTS centers and sub-centers was done as needed.
- IEC/BCC activities were carried out at various levels.
- Conducted a workshop on Lab-OT management.
- Provided DOTS to all patients in accordance to the treatment policies.
- Promoted early diagnosis of people with infectious pulmonary TB by sputum smear examination.
- Continued a system of quality control of sputum smear examination.
- Provided continuous drugs supply to all treatment centers including systems for storage, distribution, monitoring and quality control of drugs.
- Maintained a standard system for recording and reporting.
- Provided continuous training and supervision for all staff involved in TB control programme.
- Conducted a coordination meeting with private sectors, non-government organizations and External Development Partners so as to strengthen the referral mechanism from private sectors.

4.3.3 Analysis of achievements

case finding rate, FY 2069/070 to 071/72

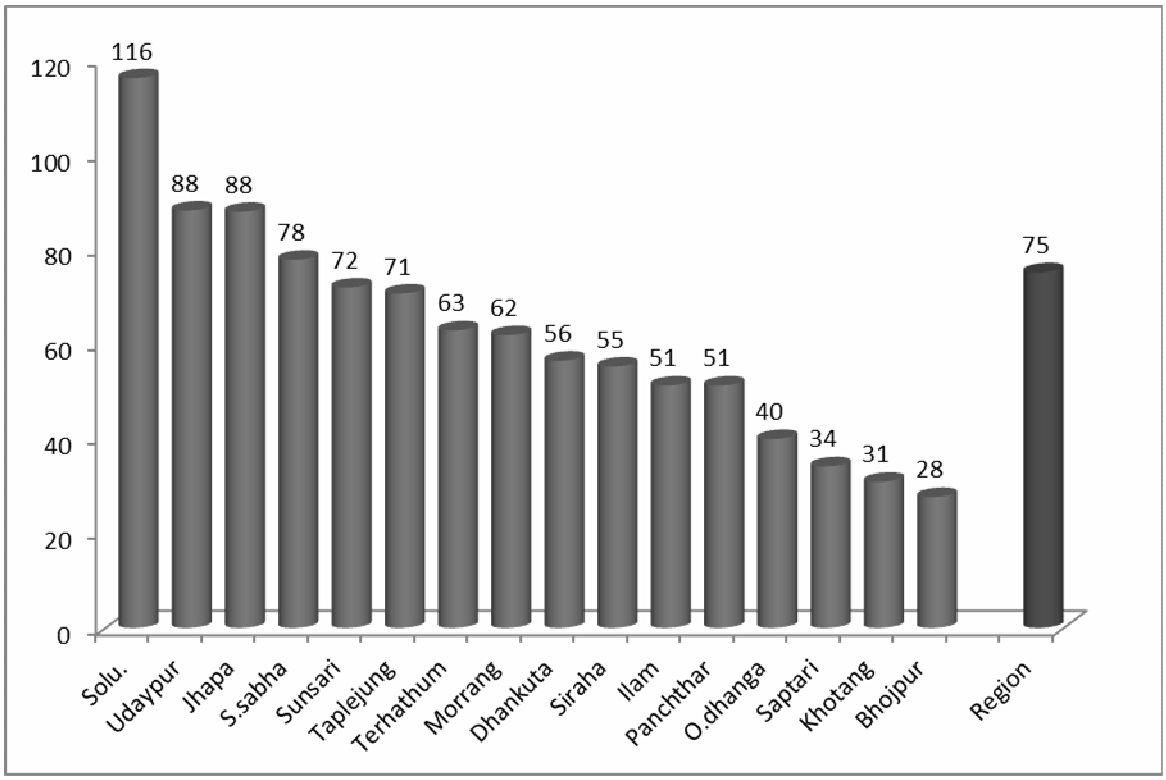


Figure 18: Trend of case finding rate, FY 2069/070 to 071/72

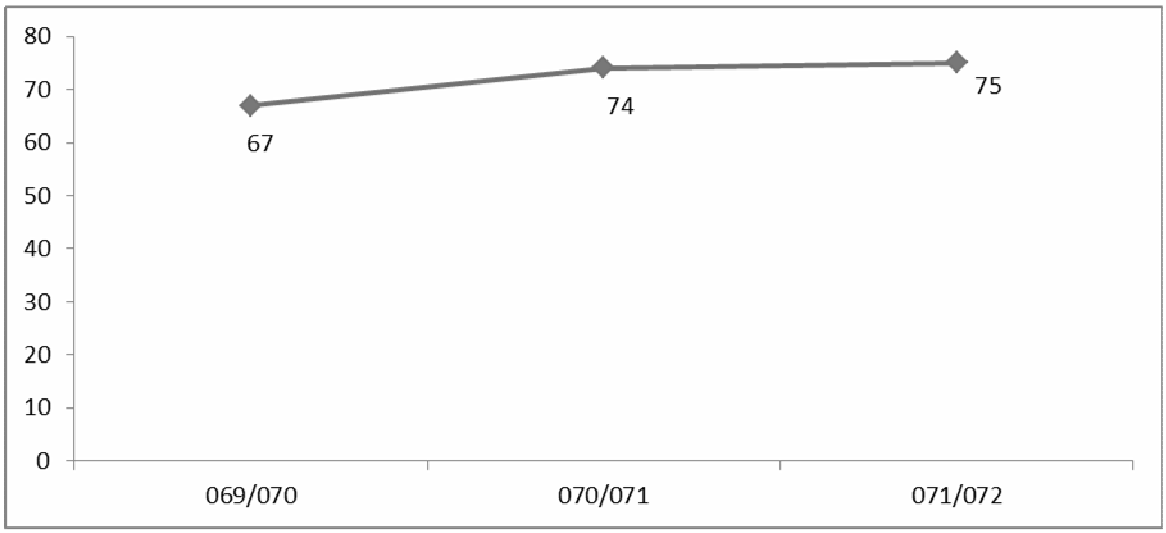


Figure 18 shows the increasing trend of case finding rate in TB at regional level. The target defined by NHSP-2 to diagnose and treat at least 85 percent of the estimated number of sputum smear positive new cases hasn't been fulfilled in the region. Low case finding of TB is one of the key issues in the region.

Figure 19: Trend of treatment success rate, FY 2069/070 to071/72

Hundred percent treatment success rate has been observed in Bhojpur, Ilam, Khotang, Okhaldhunga, Saptari, Solu, Taplejung, Terhathum and Udayapur. The overall treatment success rate of the region is 93 percent during the reporting period with the range of 82 to 100 percent.

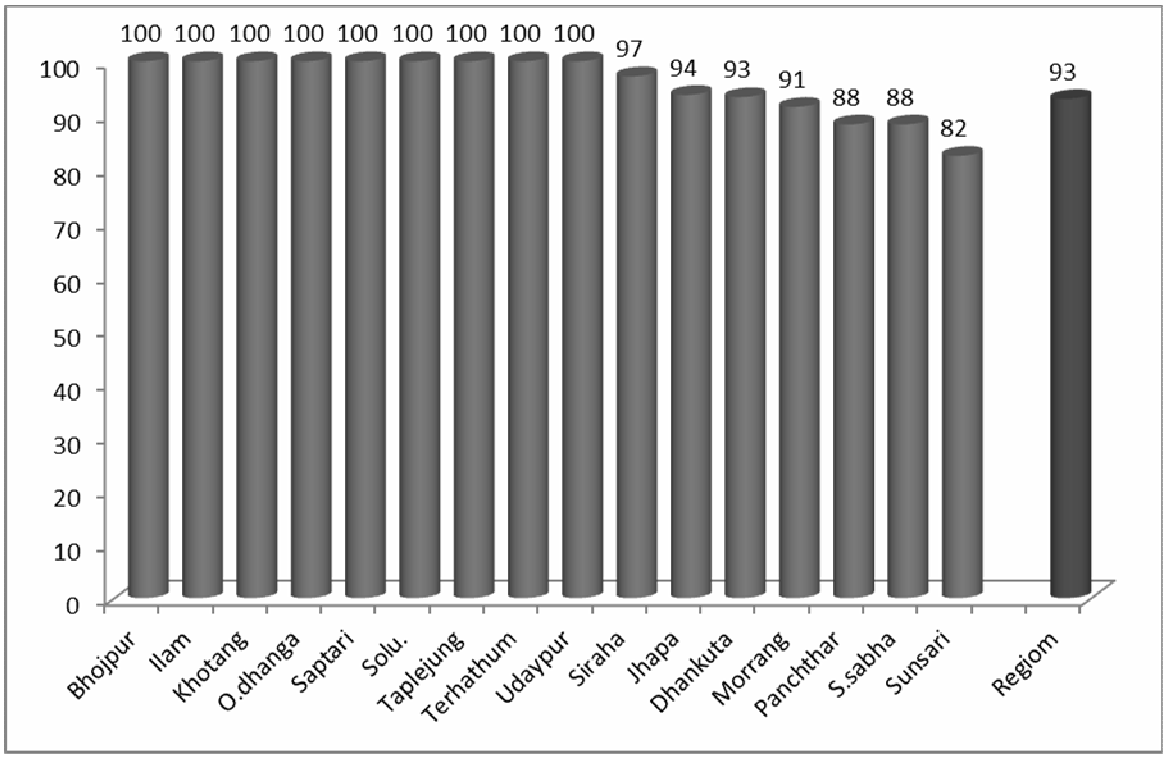
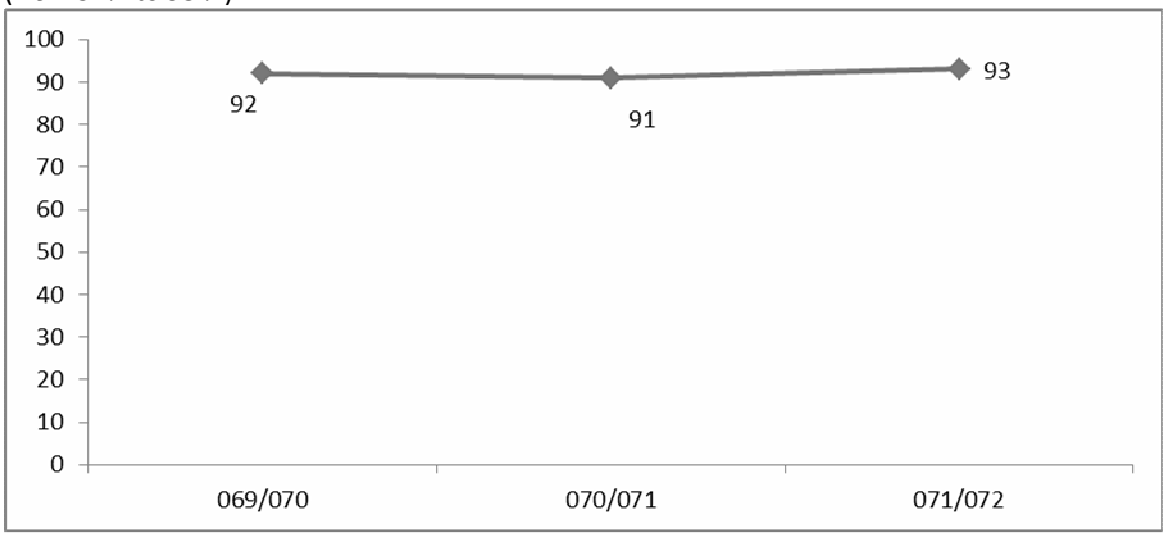


Figure 20 : Trend of treatment success rate in the region

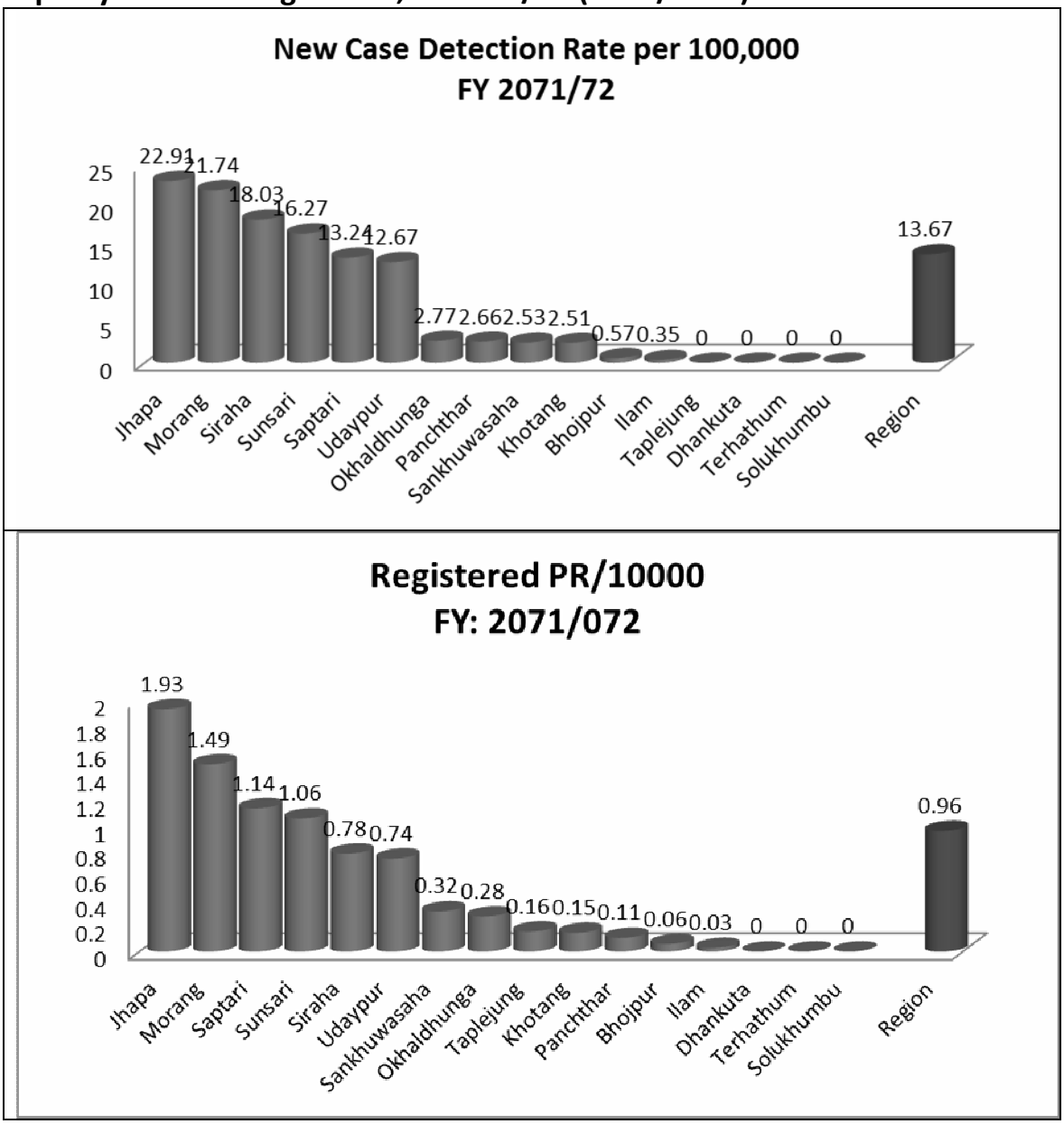
The Figure 20 below shows the trend of treatment success rate in TB over last three years period. It has slightly increased at regional level in FY 2071/72 compared to previous FY 2070/71 (from 91% to 93 %).



4.3.4 Issues/problems, constraints and action to be taken

Major Achievements	Performance Gap	Causes/Reasons	Recommended actions for improvements
High treatment success rate	Low case finding rate	Inadequate slide collection (Lab Assistant)	Increase slide collection, motivate health workers
DRTB treatment success rate is in increasing trend	Variability of Data in HMIS and TB Workshop Increasing Trend of DR TB	Concept of Correction in TB Workshop Not Effective DOTS program	Effective Supervision from the district appropriate Feedback
Income generation programs for DR patients being conducted	Increase in number of MDR case	Inadequate treatment, loss to follow up Limited capacity of TB Hostel for MDR ,	Reinforcement of case treatment as per National protocol for private Increase capacity of hostel for MDR case

Leprosy Control Programme, FY 2071/72 (2014/2015)



4.4 LEPROSY CONTROL PROGRAM

4.4.1 Background

Leprosy is one of the public health problems of eastern region. It is aimed to provide diagnostic and therapeutic services within the general health services. The program was integrated into the general health services in 1987. Multi drug therapy is available in all health institutions of the region. Leprosy burden is high in Terai districts whereas low or eliminated in hills &mountains. The regional prevalence rate as well as new case detection rate of leprosy is continually in decreasing trend. Regional Health Directorate (RHD) supervises and monitors the program in all districts within the region. Disease control activities including leprosy control activities are headed by respective officer as appointed by Regional Director in RHD.

Regional Tuberculosis and Leprosy Officer/Assistant (RTLO) is the focal person of leprosy in RHD. In addition, District TB & Leprosy Officer/Assistant (DTLO), implement the program in the respective districts. Monitoring and supervision of the activities were undertaken by the RHD to keep track of progress towards elimination. Leprosy elimination has been declared so far from the national level and the goal of elimination has already been reached by the region. There were a total of 807 new leprosy cases recorded in the region up to the end of FY 2071/72. Out of 807 new cases, 399 were recorded as MB and 408 were PB. Regarding the case load of new cases, 11 districts of the region have a total of 61 cases whereas majority of the cases (746) are in 5 Terai districts.

Goal:

Reduce further the burden of leprosy and to break channel of transmission of leprosy from person to persons by providing quality service to all affected community.

Objectives

- To eliminate leprosy (Prevalence Rate below 1 per 10,000 population) and further reduce disease burden at district level;
- To reduce disability due to leprosy;
- To reduce stigma in the community against leprosy; and
- Provide high quality service for all persons affected by leprosy.

4.4.2 Major Activities

The major activities under leprosy control program carried out in all districts of eastern region are mostly similar but more focus was given to high endemic districts. The following activities (including activities done by the supporting partners) were carried during the reporting period:

- Case detection and treatment.
- LPEP (Leprosy Post Exposure Prophylaxis) for early detection and prevention to risk populations
- Conducted review meetings on quarterly basis.
- Celebrated World Leprosy Day with different IEC/BCC & advocacy related activities.
- Basic and refresher training to the health workers.
- Management of reaction and other complications
- Carried out regular IEC/BCC activities including school & community health education activities
- Conducted program monitoring and follow up workshops at different levels

- Contact examination, skin camps
- Case validation & updating of records
- Self-care & self-help group formation and activities carried out at community level
- Income generation programmes for Leprosy-affected and people with disability.
- Promotion of DPOs with leprosy affected persons through early case detection.
- Carried out activities to mainstream leprosy disabilities to general disabilities

4.4.3 Analysis of Achievements

Figure 21: Trend of new case detection rate, FY 2069/070 to 071/72

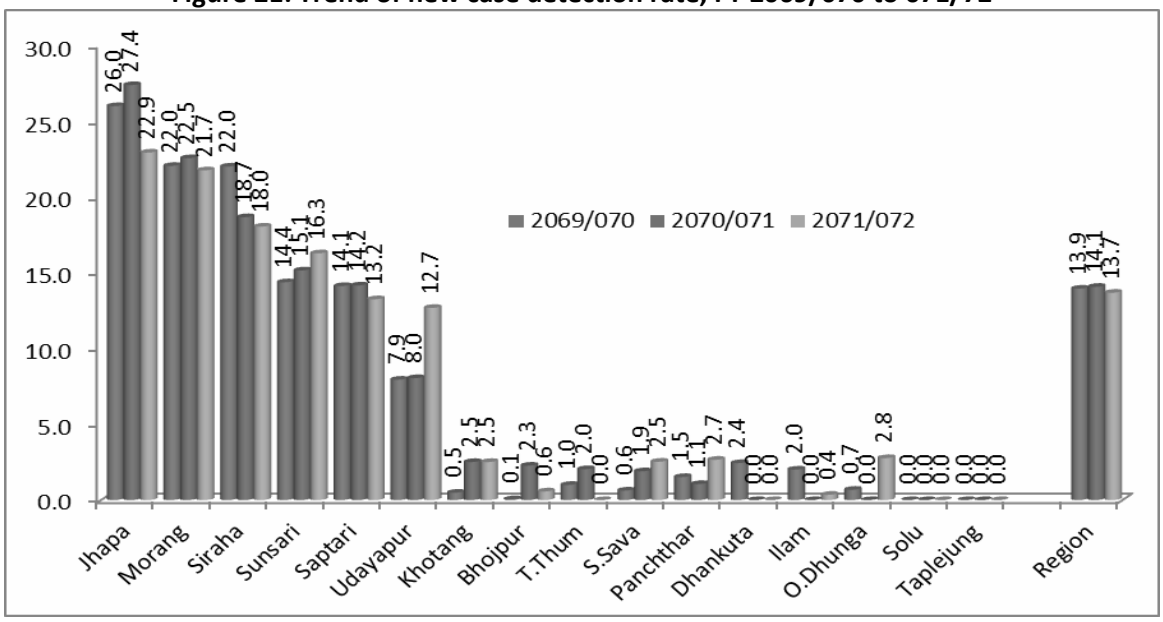


Figure 21 shows the new case detection rate of leprosy in the region which has decreased slightly (13.7 per 100,000) during FY 2070/71 compared to last two FYs (14.1/100,000). The trend of new case detection rate has decreased in Jhapa, Morang, Siraha, Saptari, Bhojpur, Terhathum, in the FY 2071/72 as compared to previous years. In other districts, it has remained either constant or increased this year. It is highest in Jhapa (22.9/100,000 population).

4.4.4 Issues/problems, constraints and action to be taken

Major achievements	Performance gap	Causes/reasons	recommended actions for improvements
leprosy elimination is being maintained in the region	still hidden cases are remained in Terai region	Unable to reach unreached population and index cases	Awareness activities and contact tracing
Piloting of LPEP in some districts	No enough interventions for disability management, inclusion and prevention	Inadequate interventions	Promote self-care/self-help groups & activities, Mainstreaming of disabilities due to leprosy to General disabilities movement

4.5 HIV/AIDS AND STDs

4.5.1 Background

HIV/AIDS and sexually transmitted diseases (STDs) are emerging as a major threat in the region. The HIV/AIDS and STDs control activities in the region is guided by the national policies and strategies. The latest national policy on HIV and AIDS (2010) have envisioned a more concrete policy framework for making AIDS free society with the overall policy aim of reducing impact of HIV among people by reducing new HIV infections. At the regional level, a number of activities have been undertaken with the joint efforts of the government and non-government organizations in order to reduce the transmission of HIV/AIDS & STDs. The Regional Health Directorate continued the role of programme monitoring at the regional level; coordinating with National Centre for AIDS and STD Control (NCASC) & different actors for better programming, enhancing joint monitoring and resource mobilization within the region. There are a total of 45 HIV counseling & testing centers (public 18, private 27), 7 PMTCT sites (providing PMTCT services to antenatal mothers) and 4 ART centers (providing anti-retroviral drugs for those in need) in the region.

Goal:

To achieve universal access to HIV prevention, treatment, care and support.

Objectives

- Reduce new HIV infections by 50 percent by 2016, compared to 2010;
- Reduce HIV-related deaths by 25 percent by 2016 (compared with a 2010 baseline) through universal access on treatment and care services; and
- Reduce new HIV infections in children by 90 percent by 2016 (compared with a 2010 baseline)

4.5.2 Major Activities

The following were the major activities undertaken under HIV/AIDS & STDs control program in FY 2070/71:

- Provided HIV testing and counseling services
- Provided antiretroviral therapy for those in need
- Prevention of Mother-to-Child Transmission (PMTCT) of HIV
- Conducted DACC meetings
- Expansion of HIV testing and counseling centers on need basis
- Celebrated World AIDS Day and Condom Day
- Conducted HIV/AIDS orientation to the HWs, community volunteers and stakeholders

4.5.3 Analysis of achievements

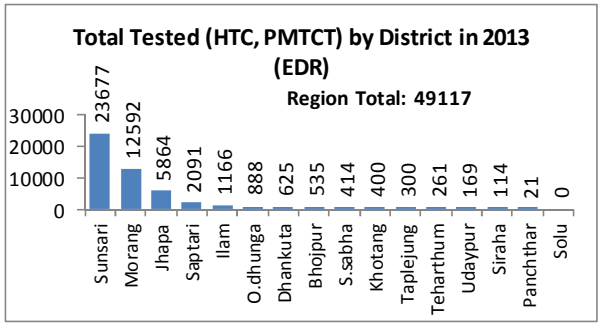


Figure 21: Total HIV Testing by district, 2013

District-wise, the highest number of HTC performed in Sunsari (23,677) followed by Morang (12,592). All the districts contributed to the regional total of 49177.

4.5.4 Issues/problems, constraints and action to be taken:

Major Achievements	Performance gaps	causes/reasons	recommended actions for improvements
Increased PMTCT,HCT ,ART sites	Increasing trend	HIV/AIDS issue yet to be integrated in all sectors/services	Enhance multi-sectoral approach
	Inadequate client friendly service sites	Insufficient PMTCT and ART sites	Expansion of ART and PMTCT sites

4.6 LYMPHATIC FILARIASIS

4.6.1 Background

Lymphatic Filariasis (LF) is a cause of lymphoedema of legs and hydrocele; impedes socio-economic development in endemic areas of the region. The disease is prevalent in the rural and slum areas of many districts, predominantly affecting the poorer sector of the community. The disease has been detected in different topographical areas ranging in attitude from 300 feet above sea level in the plain Terai ecological zone to 5,800 feet above sea level in high hill areas. However, more cases are recorded in Terai districts compared to hills in the region.12 out of 16 districts in the region are endemic zones. Khotang, Solukhumbu, Sankhuwasabha and Taplejung are the less-endemic districts in the region. Mass Drug Administration (MDA) campaign against Lymphatic Filariasis was undertaken in the endemic districts of the region in FY 2070/71. The Regional Health Directorate played a leading role in monitoring the campaign in different endemic districts and conducting a review meeting after one month of MDA campaign.

Objectives

- To interrupt the transmission of lymphatic filariasis;
- To reduce and prevent morbidity;
- To provide de-worming benefit through use of Albendazole to endemic community especially to the children; and
- To reduce mosquito vectors through application of suitable and available vector control measures (Integrated Vector Control Management).

4.6.2 Major Activities

The following major activities were carried out during the reporting period:

- Carried out MDA planning and review meeting
- Co-ordination and interaction program with HWs, partners and stakeholders
- Advertisement for MDA program using local media
- Distribution of IEC materials
- Distribution of medicine (Mass drug administration)
- Conducted supervision & monitoring of MDA programme from various levels i.e. region, district and health facility level
- Recording and reporting

4.6.3 Issues/problems, constraints and action to be taken

Major Achievement	Performance Gap	Causes/reasons	recommended actions for improvements
Timely supply of Budget and medicine	Low coverage of MDA	MDA distribution by untrained person, difficulty in mass media management	Expansion of program coverage in collaboration with stakeholders Health workers need to be mobilized for distribution of recommended drugs

	Rejection of MDA medicine from FCHV	possible promulgated adverse events	Make provision of 1-week MDA campaign by distribution of anti-filarial drugs at HFs under the supervision of HWs

4.7 SNAKE BITES

4.7.1 Background

Snake bites are the major problem in the Terai districts of eastern region. Many death cases are reported every year due to snake bites. A study done in Eastern Nepal (snake-bite-reappraisal of the situation in Easten Nepal) revealed that snakebite was more frequent between the ages of 10 and 40 years (76%) & in males (73%) and the majority (80%) of the snakebites was observed during the monsoon (Sharma, 2002).

4.7.2 Analysis of achievements

As shown in Figure 24, a total of 60 snakebite cases (poisonous) has been reported in the region in the FY 2071/72, which was higher in the last FY 2070/71. Like last FY, S.sava has reported the highest number of the cases (15) in the region this FY.

Figure 24: Number of snakebites by districts, FY 2071/72

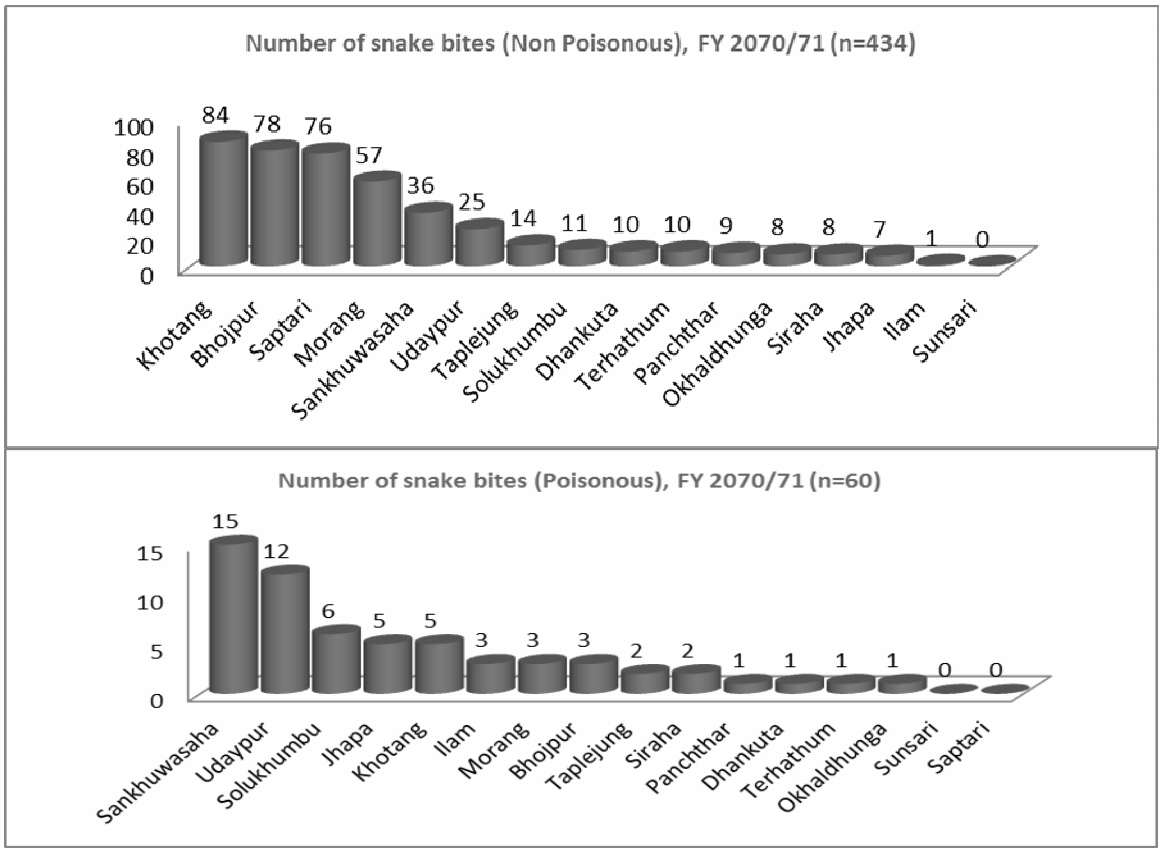


Figure 25: Number of non-poisonous snakebite by districts, 2071/72

Figure 25 indicates that a total of 434 persons in the region have been treated for Non-poisonous snake bites in FY 2071/72. Further, the number of persons treated for Non-poisonous snake bites are highest in Khotang (84) followed by Bhojpur (78) this year.

4.7.3 Issues, Problems, Constraints and action to be taken

Major Achievement	Performance Gap	Causes/reasons	recommended actions for improvement
Decreasing the no. of death from snake bite	Slightly snake bite cases, but no sufficient supply of anti-snake venom (ASV)	No timely procurement and distribution	Adequate stock need to be maintained in high risk areas School awareness program to be conducted in the high risk areas
	Difficulty in management of snakebite cases because only few HWs have been provided its training	Inadequate training for service provider	Provide case management training to the health workers

5 CURATIVE SERVICES

5.1 Background

The curative services provided to the people throughout the region are guided by the national policy. The Regional Health Directorate took a leading role for monitoring of private health institutions including hospitals, nursing homes and polyclinics operational within the region as needed. Curative health services aims to provide appropriate diagnosis, treatment and referral through the network of PHC outreach to specialized hospitals. Curative (out-patient, in-patient and emergency) services are highly demanded component of health services by the people.

The Interim Constitution of Nepal 2063 has emphasized that every citizen shall have the rights to basic health services free of costs as provided by the law. Ultimately, government of Nepal decided to provide essential health care services (emergency and inpatient services) free of charge to poor, destitute, disabled, senior citizens and FCHVs up to 25 bedded district hospitals and PHCCs (December 15, 2006) and all citizens at SHP/HP level (8 October, 2007).

OBJECTIVE:

The overall objectives of curative services is to reduce morbidity, mortality and to provide quality health services by means of early diagnosis, adequate as well as prompt treatment and appropriate referral as needed in order to improve quality of life.

TARGET:

To provide service to all patients attending health facilities with appropriate diagnosis, treatment and/or referral to specialized health facilities.

Major Activities

Curative health services were provided through the existing health facilities on an outpatient including emergency where ever available and inpatient basis. The following major activities were carried out under the curative services during the reporting year:

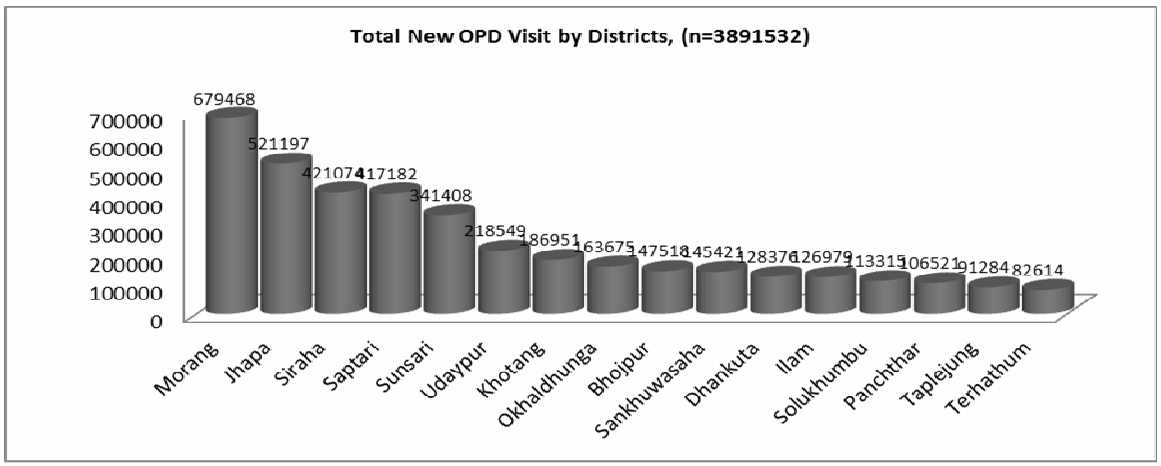
- In-patient and outpatient services (including emergency services wherever available) were provided by public, private and I/NGOs run hospitals & nursing homes.
- General health camps were organized in Morang and Siraha districts with the support from a medical team of different public and private hospitals. The cases screened in the health camps for surgical interventions were managed through different hospitals selected by the Regional Health Directorate.
- Essential drugs and other logistic materials were managed to provide to all health institutions as required.
- Provided VCT and PMTCT services including provision of treatment for opportunity infections and anti-retroviral therapy.
- Carried out regular investigation services (radiological and pathological).
- Provided treatment for snake bite and rabies.
- Provided CAC and PAC services along with post family planning services.
- Carried out regular services on maternal and child health.
- Provided free health services to the targeted groups.
- Provided necessary services to the medico legal cases.

- Carried out routine services to malnourished children (<5 years) from Nutrition Rehabilitation Center (NRC).
- Record keeping and reporting were done on a regular basis at all health institutions.

5.2 Analysis of Achievement

The analysis of achievement is mainly done into the two sections i.e. outpatients and inpatients services. Outpatients' services cover all kind of services provided through different level of service delivery outlets, for instance from SHPs to tertiary level hospitals whereas inpatients services are provided only in hospitals.

Figure 26: Total New OPD Visit by Districts during FY 2071/72

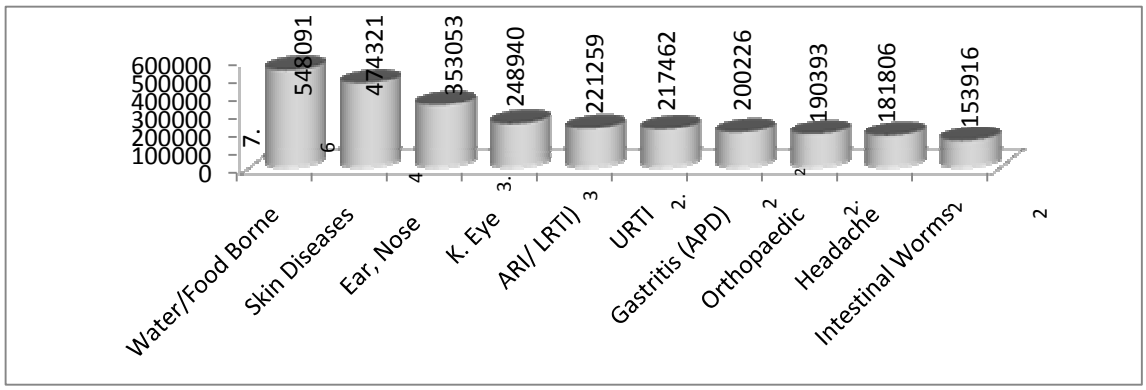


A total of 3891532 outpatients new visits were reported in 2071/72 in eastern region. The highest number of outpatient's new visits 679468 was recorded in the Morang followed by Jhapa 521197. The lowest number of outpatient's new visits was recorded in Terhathum 82614 (Figure 26). Of total OPD visit, 55.8% were female and 44.2% were male patients.

Out Patient Morbidity

Figure 28 shows the top ten causes of outpatients' morbidity in 2071/72. Water/food borne disease was recorded the number one among the top ten outpatients' morbidity (7.3%) followed by Skin disease (6.3%), Ear/Nose infection (4.7%), Eye problems (3.3%), ARI/LRTI (3.0%). Other major reported causes for outpatients' morbidity are URTI (2.9%), APD (2.7%), Ortopodics (2.5%), Headache (2.2%) and intestinal worms (2.1%).

Figure 28: Top Ten Diseases during FY 2071/72



5.3 Issues/problems, constraints and action to be taken

Major Achievement	Performance Gap	Causes/reasons	Recommended actions for improvement
Many districts Hospitals are upgrading to 50 bed	Human resources problems	Human resources are not sufficient: sanctioned vs fulfilled, vacant positions, no revision of sanctioned positions as per standard norms, workload and number of total population to be served	Fulfillment of vacant positions-priority need to be given to the hospitals with high workload Preparation of New Human Resource Plan, recruitment and deputation according to it.
Involvement of private sector is increasing in hospital sector	Inadequate budget	Insufficient budget for repair and maintenance of hospital equipment including no provision of biomedical engineering unit	• Provision of sufficient budget for repair and maintenance • Capacity building of relevant human resources at hospital for equipment repair and maintenance Develop concept to establish a biomedical engineering unit at hospitals
Hospital strengthening program has been launched	Inadequate infrastructure	Insufficient quarters for Doctors, Nursing and Paramedical staffs	Construction of quarters on the basis of hospital capacity and number of bed in the hospital.
	Inadequate equipments	Lack of instruments – C.T. scan, Echocardiography Machine U.S.G. colour doppler etc as per the capacity of the hospitals	Provision of instruments to the hospitals according to its level and specialty services provided

6 SUPPORTING PROGRAMMES

6.1 HEALTH TRAINING

6.1.1 Background

MoHP accords high priority for the development of competent human resource through various means of training activities through developing trained human resource for better improvement in health care service delivery. National Health Training Centre is an apex body for human resource development towards meeting NHSP Outputs and MDG 4, 5, and 6 for the MoHP.

The Regional Health Training system is an integrated and cross cutting efforts towards meeting training needs to support the quality health care delivery throughout the region. It supports to policies, plans and activities of MoHP to be addressed through training to contribute in achieving goals and targets. It provides technical as well as managerial inputs at the regional, district and community level training programs with appropriate and quality training need assessment, training delivery, monitoring, evaluation, post training follow up and research related activities on public health and health education.

The overall goal of RHTC is to produce/prepare efficient health service providers by means of training to contribute to deliver quality health care services towards attainment of the highest level of health status. The objectives of the program are:

- Assess training requirements of Health Workers and prepare training plans based on the program's requirement.
- Plan, implement and train health workers as demanded by programs.
- Design, develop and refine teaching, learning materials to support implementation of training programs.
- Develop/improve capacity of trainers to deliver quality training at central, regional and district level.
- Support RHDs and DHOs in organizing, implementing and evaluating the training programs.
- Coordinate with all National and International, Governmental and Non-Governmental Organizations to avoid duplication of training and improve quality of training.
- Orient newly recruited health workers on health programs.
- Supervise, monitor, follow-up and evaluate training programs.
- Conduct operational studies to improve training efficiency and effectiveness.
- Organize International Training as per need.
- Establish TIMS for the quality recording and reporting systems of all training programs at central, regional, district, and community levels.

6.1.2 Major Activities

RHTC provided following training activities:

- FCHV training of trainers
- CoFP counseling
- Gender based violence
- General ToT
- Infection prevention
- HFOMC orientation
- Sr AHW
- Supervision and monitoring

- ToT on hospital Management

District (public) health offices provided the following trainings:

- FCHV Basic Training (Ist Modular -9 Days) and (2nd Modular -9 Days)
- TB refresher training to VHW/MCHW/FCHV and Smear preparation and late patient tracer
- Orientation to low performing Health Management Committees (HMCs)
- Health related training to social and health teacher and journalists.
- Training for control of vector borne disease
- Training for Mass Drug Administration-Filaria to all health workers in selected districts
- CB-NCP, chlorohexidine navi care and IYCF training in selected districts
- Peer education training of trainers to selected teachers and 8-10 class students
- Population management training to health workers in selected districts
- GBV orientation to health workers and selected teachers and 8-10 class students
- Performance based managent system-PBMS orientation to selected health workers and district supervisors.

6.1.3 Analysis of Achievement

Table 16: Target vs achievement for FY 2071/72 of ERHTC

SN	Program	Target	Unit	Ach	%	Bud	Exp	%
1	CoF/Couns	54	Person	54	100	1006	1006	100
2	ASRH	50	person	50	100	890	890	100
3	Emergency in RH (ToT)	10	person	20	100	385	385	100
4	Non Health Personel Orientation	25	person	25	100	330	330	100
5	JESI	9	Group	9	100	2250	2250	100
6	AHW	30	person	30	100	4030	4030	100
7	Sr AHW	35	person	35	100	4900	4900	100
8	FCTC	20	Person	20	100	400	400	100

6.1.4 Issues, Problems/Constraints and Action to be Taken

Major Achievements	Performance gaps	Causes/reasons	recommended actions for improvement
Fulfilled the sanctioned post of training officers	Physical infrastructure	No well-equipped training hall	Repair and maintenance of buildings and equipment
	inadequate training opportunity	Least training program and for limited persons	Allocation of Training program

6.2 HEALTH EDUCATION, INFORMATION AND COMMUNICATION

6.2.1 Background

Following national health policy in 1991, National Health Education, Information and Communication Centre (NHEICC) was established under the MoHP in 1993, with the mandate to give high priority to information, education and communication in the health sector. Since 1994, IEC activities have been decentralized and districts are involved in preparing in work-plan and developing IEC materials locally as per guideline of NHEICC. All

districts have health education, information and communication programs since FY 2051/52 for developing, producing and disseminating messages to promote and support health programs and services in an integrated manner. The health education and communication units in the district Health Offices works to meet the increasing demand for health education services by implementing IEC activities utilizing various media and methods according to the needs of the local people in the district. Local media and languages are used in the district for dissemination health messages so that people can understand health messages clearly in their local context.

The goal of the NHEICC is to contribute to attainment of the highest level of health of the people of the country and to contribute and support in the achievement of MDGs 3, 4, 5, 6 and 7; and goal and objectives of other programs and services

The general objective of IEC for health is to raise the health awareness of the people as a mean to promote improved health status and to prevent disease through the efforts of the people themselves and through full utilization of available resources. The specific objectives of the programs are to:

- Increase awareness and knowledge of the people on health issues
- Increase positive attitudes towards health care
- Increase healthy behavior
- Increase participation of the people in the health intervention programs at all levels of health services
- Increase access to new information and technology on the health programs for the people
- Promote environment health and hygiene
- Control the tobacco and Non Communicable Diseases (NCDs)

6.2.2 Major Activities

Regional Level

- Radio program airing from FM
- Orientation to journalist and stakeholders on health

District Level

- Electronic materials managed to District Health Education Corner strengthening
- Health Exhibition in community
- Production of health materials
- Distribution of health education materials in HFs
- School health programme
- Conduction of health education corner in each health facilities
- Interaction of health education in community
- Program on Environmental / occupational health and hygiene
- Community health promotion campaign
- Award to FCHVs and encourage FCHVs to promote health education
- Interaction of health education with journalist
- Production and transmission of health messages through FM
- Transmission of health messages through FM
- Transmission of health message about sterilization through FM

- Supervision and Monitoring of IEC activities
- Awareness program on control of epidemics
- Awareness program against Gender Based Violence
- Orientation for control of smoking and non-communicable diseases in Health education programme
- Orientation to teachers in Health education programme

6.3 LOGISTICS MANAGEMENT

6.3.1 Background

Logistic support is one of the important components to ensure effective and efficient delivery of health services as well as ensuring rights of citizens of having quality of health care services. Regional Medical Store and district store are responsible for timely supply of drugs, equipment, contraceptives, vaccine and other commodities to the service outlets including storage and maintenance of inventory.

The overall objective of the program is 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 government health institutions in the region.

6.3.2 Major Activities

- Repacking of Drugs & other goods
- Supply of Drugs & other goods
- Repair & Maintenance of Vehicle, Cold chain equipment and others
- Store Supervision
- Medical Store Maintenance & Construction

6.3.3 Analysis of Achievement

Table 17: Target vs Achievement of ERMS, FY 2071/72

Activities	Allocated budget	Expenditure	Target	Achievement	percentage
Supply Repacking of Drugs & other goods	5600000	2746169	1	1	100%
Repair & Maintenance of Vehicle, Cold chain equipments & others	400000	353831	3	3	100%
Store Supervision	315000	315000	3	3	100%
fuel	525000	279906	3	3	100%
National polio program	175000	75600	1	1	100%

Table 18: Supply of Key Commodities to Districts by ERMS (FY 2071/72) (in Quantity)

SUPPLY STATUS OF KEY COMMODITIES ERMS, FY 2071/072								
District	**Condom**	**Depo**	**Pills**	**ORS**	**COTRIM P**	**IRON**	**VIT A**	**ZINC**
Bhojpur	0	23400	21600	8500	28000	0	63400	0
Dhankuta	32000	17400	4320	25000	0	0	52800	0
Illam	0	33200	18720	10000	40000	41250	85000	0
Jhapa	60000	74600	34400	47000	46000	46000	261600	0
Khotang	0	15000	14400	6500	35000	40000	45000	0
Morang	0	51200	46350	50200	30000	91250	295000	0
Okhaldhunga	0	8000	10080	8200	45000	70000	47400	0
Panchthar	40000	29000	8640	21400	35000	20000	72600	0
Sankuwasava	0	21800	15167	17200	30000	30000	52400	0
Saptari	123000	40000	14400	36300	92000	85250	228200	0
Siraha	0	47600	43200	37000	75000	41250	237600	0
Solukhumbu	0	16200	4320	15800	20000	41250	35600	0
Sunsari	100000	62400	14400	35400	82000	85250	257200	0
Taplejung	0	18300	15840	20865	47000	41500	43200	0
Tehrathum	0	6200	1440	10000	60000	57000	36000	0
Udayapur	52000	28000	4320	24500	115000	96500	119500	0
TOTAL	407000	492300	271597	373865	780000	786500	1932500	0

Table 19: TB/Leprosy Drugs Received & Supplied Status by ERMS, (FY 2069/070 to 071/72)

SN	Items	Unit	Opening balance	Received	Total Received	Total Issued	Balance	*FY069/070*	*FY070/071*	*FY071/072*
1	HR(75+150)mg	*Tab.*	*32328*	2709504	2741832	1981056	760776	2018968	2741832	1981056
2	HR Child	*Tab.*	*44954*	66528	111482	64946	46536	123882	92638	64946
3	HRZ Child	Tab.	12340	52920	65260	40732	24528	64932	65260	40732
4	HRE	Tab.	9256	279552	288808	241096	47712	245280	288808	241096
5	HRZE	Tab.	139744	1378944	1518688	1242000	276688	1507968	1518688	1242000
6	Ethambutol 400 mg	Tab.	1960	2200	4160	3880	280	2000	0	3880
7	Pyrazinamide 400 mg	Tab.	0	1344	1344	868	476	672	0	868
8	Isoniazid 100 mg	Tab.	2500	7000	9500	3100	6400	672	2200	3100
9	Rifampicin	Cap.	0	3500	3500	2900	600	0	0	2900
10	Streptomycin Inj	Vial	4850	37000	41850	35960	5890	33864	41850	35960
11	Glass Slide	Pcs.	28000	167500	195500	157500	38000	179900	195500	157500
12	Sputum Container	Pcs.	36000	226000	262000	186200	75800	133000	262000	186200

Table 20: ASVS and ARV Received and Supplied Status by ERMS, FY 2071/72

SN	Items	Unit	Opening balance	Received	Total Received	Total Issued	Balance	*FY069/070*	*FY070/071*	*FY071/072*
1	Polyvalent ASV	Vial	335	5280	5615	4355	1260	4155	1960	4355
2	Rabies Vaccine	Amp	5220	50460	55680	45630	10050	34700	5220	45630

Table 21: Malaria Drugs Received and Supplied Status by ERMS, FY 2071/72

SN	Items	Unit	Opening balance	Received	Total Received	Total Issued	Balance	***FY069/070***	***FY070/071***	***FY071/072***
1	Chloroquine 150 mg	Tab	36000	100000	136000	85500	50500	108000	85500	85500
2	Primaquine 7.5 mg	Tab	5000	50000	55000	39000	16000	14500	39000	39000

Table 22: EPI Program Items Received and Supplied Status by ERMS (FY 2069/070 to 071/72)

SN	Items	Unit	Opening balance	Received	Total Received	Total Issued	Balance
2	BCG Diluent	Amp	8900	35200	44100	35740	8360
3	DPT HepB Hib	Vial	12050	59700	71750	54100	17650
4	Polio 10	Vial	14500	57100	71600	54050	17550
5	Polio 20	Vial	0	0	0	0	0
6	Polio Dropper	Pcs.	14500	57100	71600	54100	17500

SN	Items	Unit	Opening balance	Received	Total Received	Total Issued	Balance
7	IPV	Vial	0	40100	40100	35400	4700
8	PCV	Vial	0	85800	85800	54700	31100
9	Measles / Rubela 10	Vial	8550	46200	54750	39300	15450
10	Measles Diluent	Amp	8550	46200	54750	39300	15450
11	TD 10	Vial	9700	40800	50500	38000	12500
12	J.E. Vaccine	Vial	0	30000	30000	25900	4100
13	J.E. Diluent	Vial	0	30000	30000	25900	4100
15	AD Syringe 0.05ml	Pcs.	50300	800000	850300	811300	39000
15	AD Syringe 0.5ml	Pcs.	91101	141601	232702	232402	300
16	AD Syringe 2ml	Pcs.	5300	0	5300	5000	300
17	AD Syringe 5ml	Pcs.	146600	0	146600	128600	18000
18	Safety Box	Pcs.	0	11500	11500	8550	2950

ERMS Expectations

- Timely Supply of Essential Drugs and other goods from Centre to RMS.
- Timely sharing of Supply and Procurement plan of Drugs and other commodities by Centre with RMS and districts.
- Districts should follow and implement Pull system for better Logistics Management.
- Districts should forward the correct LMIS report timely to LMIS unit/LMD & ERMS in each quarter.

6.3.4 Issues, Problems/Constraints and Action to be Taken

Major Achievements	Performance gaps	causes/reasons	recommended actions for improvements
Timely supply of received commodities to the districts.	Infrastructure	Insufficient store space in the RMS.	Extension of rooms or Construction of new Storage building.
Prompt response and supply of commodities to Districts as per their requisition/emergency requisition	supply chain	Over stocking of some drugs	Supply should be through one-door system

	Inadequate budget	Insufficient maintenance budget for generator, cold room, transformer, vehicle & electric spare	Provision of extra budget for all maintenance work
	Recording and reporting	Not regularly followed Web base LMIS & E-mailing system	Should be strictly followed by all district

6.4 PUBLIC HEALTH LABORATORY SERVICES

6.4.1 Background

Under curative services, the Health policy aims to provide diagnostic laboratory services in all the hospitals from central to the periphery. NHSP II (2010-2015) envisages Public Health Laboratory Service strengthening at all levels. In this regards, National Public Health Laboratory (NPHL) has be designated as nodal institute for Policy, guidelines and over all framework for capacity building development in laboratory sector. Attention will be given to strengthen laboratory procedure and communication between national, regional and district levels and strengthening the systems ensuring the availability of essential equipment and logistics.

At present there are three zonal hospital based laboratories, 13-district hospital based laboratories, thee other government hospital lab, and 49-PHCC based level laboratories. In addition, there are 97 laboratories in private sector, and one tertiary level lab is in BPKIHS.

The goal is to provide quality health laboratory service which is accessible to every citizen at affordable cost. The objectives of the program are:

- To affirm government commitment and support for the organization and management of efficient, cost-effective and sustainable health laboratory services.
- To strengthen laboratory services for supporting diagnosis, treatment, surveillance, prevention and control of diseases.
- To ensure the quality of the health laboratory through an established quality system.
- To empower the establishment, implementation and monitoring of the national health laboratory program,regional regulatory mechanism for regulating all health laboratories.
- To ensure adequate financial and human resources to meet the requirements for the health laboratory services.
- To comment to ethical values in laboratory practice, including patient confidentiality, adherence to professional codes of conduct and ethical research practices.
- To encourage research and collaboration to inform and improve the quality of health laboratory services.

6.4.2 Major Activities

- Regular investigation of different lab services

- Lab test for emergency of influenza, encephalitis and dengue fever

6.4.3 Analysis of Achievement

Table 23 presents the summary of performance of lab section of the hospitals/PHCCs of eastern region during FY 2071/72. Among different laboratory services, Hematology related services ranked highest (55%) which was followed by Biochemistry (28%) and Parasitology (8 %) in 2071/72.

Table 23: The percentage of laboratory services in FY 2071/72 by districts

Haematology	55
Biochemistry	28
Parasitology	8
Immunology	3
Bacteriology	3
Virology	3
Cardio enzyme	0.2
Histology	0.1
Cytology	0.1
Immuno-Histo-chemistry	0.001

6.4.4 Issues, Problems/Constraints and Action to be Taken

Major Achievements	Performance gap	causes/reasons	recommended actions for improvements
laboratory services has been strengthened	reporting and recording	Poor reporting of lab and radiology data	complete and regular reporting and strengthen monitoring and feedback system

6.5 PRIMARY HEALTH CARE REVITALIZATION

6.5.1 Background

In Nepal, PHC has had a long history that was reinforced by the Declaration at Alma Ata, and in 1991 culminated in the National Health Policy endorsing PHC. National Health Policy 1991 was a turning point in delivery of Primary health care services in the rural areas of Nepal.

The concern for the poor and marginalized people both in urban and rural areas has been the priority of the government. In order to materialise the constitutional commitment (Interim Constitution, 2007) of fundamental right of basic free health care, MoHP introduced a policy of providing “Free Health Care Services” to the population in a phased manner to enhance access to primary health care services for every citizen on an equal footing with special consideration for the safety net for the poor, ultra-poor, destitute, disabled, senior

citizens and Female Community Health Volunteers (FCHV). Consequently, in 2009 (Jestha 2065), Ministry of Health and Population (MoHP) embedded in principles of essential care and equity constituted a new division Primary Health Care Revitalization (PHCRD) under the Department of Health Services. The new division is envisaged to revitalize PHC in Nepal by addressing emerging health challenges in close collaboration with other DoHS divisions and relevant actors. The division has 3 thematic focuses: National Free Health Care, Social Health Protection, and Urban and Environmental Health

The goal is to reduce morbidity and mortality especially of poor, marginalised and vulnerable people by securing the right of the citizens to quality essential health services.

Objectives

- To increase access to and utilization of quality essential health care services by ensuring availability of essential drugs in both urban and rural health facilities throughout the year
- To achieve universal coverage of essential health services by developing a more comprehensive approach (structures or systems) with the aim of protecting the population against the financial risks of expensive health care
- To provide quality essential health care services to the municipal population at accessible delivery points through urban health clinic in partnership with MoLD/Municipality
- To promote environmental health specifically hygiene and sanitation amongst population in conjunction with other essential health care services for improved hygiene practices in partnership with related agencies

6.5.2 Major Activities

The following were the major activities carried out during FY 2070/71:

- Free health services to marginalized population and areas (Health camp-Dental, ENT, General Surgery, General Health Services)
- Uterine prolapsed screening and surgery
- Training on rational use of drugs for prescribers
- Financial support to poor and ultra-poor in case of referral
- Hiring of health workers on contract for urban health
- Provision of health services by contract staff in municipality areas in coordination with municipality
- Purchasing and supply of essential drugs
- Financial support for health institution for administrative management
- Formation of elderly club and weekly health check up program
- Construction of buildings in municipality area
- Community health insurance in Mangalbare PHC
- Quarterly meeting of HMC for monitoring of urban health program

6.5.3 Analysis of Achievement

Table 26 below presents the different types of free health services to different category of disadvantaged people by hospitals in the region during FY 2071/72. A total of 17210 ultra-poor people received free OPD, emergency, inpatients and referral services from the hospitals across the region. Further, 688 FCHVs had received different hospital services at free of cost from hospital during the same period.

Table 26: Free health services provided to disadvantaged people from hospitals (OPD, inpatients, emergency and referral) during FY 2070/71.

Services	Ultra poor/poor	Disable	Helpless /Destitute	Senior Citizen	FCHV
OPD	13627	922	3930	31113	624
Emergency	1870	331	724	4521	51
Inpatients	3271	247	1250	5162	12
Referral	132	31	125	139	1
Total	17210	1531	6029	40935	688

6.5.4 Issues, Problems/Constraints and Action to be Taken

Major Achievements	Performance gap	causes/reasons	recommended actions for improvements
Utilization pattern of Free health services to marginalized population and areas has been increased	Difficulty in procurement of essential drugs	Variation in provision of *Sarbajanik Kharid Ain* (total volume wise) and instruction from LMD (item wise). Difficult to procure item wise drugs	Provision of procuring drugs according to *Sarbajanik Kharid Ain*
	free health service in urban areas	No provision of subsidy for OPD cases in urban health clinics	Provide subsidy for as per OPD cases in urban health clinics

6.6 PERSONNEL ADMINISTRATION MANAGEMENT

6.6.1 Background

Eastern development region consists of 16 programme districts. Regional Health Directorate is responsible for the effective management of the entire health programme by the mobilization of the extensive network of health workers of the region. The staffing pattern and their proper mobilization is an important factor for the effective implementation of the programme.

Objectives

- Best utilization & mobilization of existing human resource to deliver the quality health program.
- Regular monitoring and supervision of program through the proper mobilization of the human resources.
- Identification of training need of staffs for the capacity building of the human resource.
- Performance based assessment, appreciation and motivation of the staffs.

6.6.2 Major Activities

- Upgraded 25 health staffs of different designations from 4th to 5th level
- Appointed 183 temporary health staffs of different designations (4th and 5th level)
- Transferred 205 health staffs of different designations of 4th and 5th level within the region
- Personal information of all the staffs of the region were updated and computerized.

- The information of the private and non- governmental health institutions were updated and computerized.
- Collected the information of the private health institutions, which are running without getting approval.

6.6.3 Analysis of Achievement

Table 27: District-wise information on the sanctioned and vacant positions in ERHD, FY 2071/72

District	Total Post	Vacant	Fullfill
Taplejung	349	119	230
Panchthar	269	94	175
Ilam	338	115	223
Jhapa	380	97	283
Morang	492	152	340
Sunsari	421	120	301
Dhankuta	249	94	155
Terhathum	219	60	159
Sankhuwasaha	277	98	179
Bhojpur	396	132	264
Solukhumbu	239	64	175
Okhaldhunga	319	106	213
Khotang	443	154	289
Udaypur	302	118	184
Saptari	740	303	437
Siraha	712	333	379
Region	6145	2159	3986

The above Table 27 shows the district wise situation of the sanctioned and vacant posts. Siraha district has the highest 333 vacant posts out of 712 sanctioned posts, followed by Khotang with 154 posts out of 443.

Table 28 below, also reveals the fact that the lack of human resources in the sanctioned position is the major problem of ERHD.

Table 28: Total post status of organizations in FY 2071/72

Hospital	Total Post	Vacant	Fullfill
Mechi Zonal Hospital	105	41	64
Koshi Zonal Hospital	221	51	170
Sagarmatha ZH	99	40	59
Lahan Hospital	29	9	20
Rangli Hospital	31	10	21
Katari Hospital	25	11	14
Udayapur Hosp	59	31	28
RMS	11	2	9
RHTC	19	6	13

6.6.4 Problems/ Issues and Recommendations

Major Achievements	Performance gaps	Causes/reasons	Recommended actions for improvements
All SHP are upgraded into HP	Human resource	absenteeism of health workers	Strict implementation of policy
	institute registration and renewal	Some of the health institutions are running without approval and without renewal	Need to take action in accordance to the policy

6.7 FINANCIAL MANAGEMENT

6.7.1 Background

For the effective management and to support the implementation of health programme, preparation of annual budget, recording, reporting and auditing are essential components of financial management. There is finance section responsible for this management in the region.

Objectives

- To obtain budget in time.
- To achieve 100% expenditure of budget in accordance with work-plan as per GoN rules and regulation.
- Facilitate and support auditing process.
- To reduce and minimize irregularities and outstanding in the region.

6.7.2 Major Activities

- Preparation of programme and budget.
- Preparation of monthly, quarterly and annual fiscal report.
- To keep the books of accounts and submit financial reports in time.
- Facilitate and manage the programme budgeting and expenditure process in line with the government rules and regulations.
- Auditing of expenditure.

6.7.3 Analysis of Achievement

Table 29: Budget vs Expenditure by districts, FY 2071/72 (in NRS 000)

Districts	Total Budget (Released)	Total Expenditure	% of expenditure
Bhojpur	23059	18886	*82*
Dhankuta	34774	24427	*70*
Illam	28372	23659	*83*
Jhapa	145395	115773	*80*
Khotang	50015	43841	*88*
Morang	96771	84833	*88*
Okhaldhunga	63546	56665	*89*

Panchthar	57367	52545	*92*
Sankhuwasabha	48786	41589	*85*
Saptari	77673	76904	*99*
Siraha	84950	74899	*88*
Solukhumbu	35204	29712	*84*
Sunsari	100391	74106	*74*
Taplejung	128681	120483	*94*
Terhathum	13036	11342	*87*
Udaypur	50215	40560	*81*
ERHD	25588	19143	*75*
Regional Total	1063823	909366	*85*

Table 29 shows the district wise budget vs expenditures of the region. The budget vs expenditure rate of the regional office alone is 85% as compared to total released budget.

Table 30 below present the annual physical and financial achievement of the different program conducted by ERHD. Monitoring/Evaluation, IEC/BCC, Community health programs achieved 100% physical progress except others and regional total is 86%.

Table 30: Physical and Financial Achievement of ERHD FY 2071/72

SN	Program Head	Physical Progress	Financial Progress	Remarks
1.	Child Health	95	47	
2.	EDCD	70	35	
3.	PHCRD	100	97	
4.	Management	68	69	
5.	Family Health	58	48	
6.	Leprosy	99	98	
7.	Monitoring/Evaluation	100	100	
8.	IEC/BCC	100	100	
9.	Community Health	100	100	
10.	Population	63	63	
11.	TB Program	100	86	

6.8 MANAGEMENT

6.8.1 Background

To develop skills in record keeping, analysis and use of information for planning and supervision, integrated HMIS implementation strategies started in 1993. Efforts are being done to utilize HMIS information in planning, monitoring, supervision and evaluation at regional and district level.

Objectives

- To collect health service delivery information from all levels of service delivery institutions.
- To monitor the coverage, continuity and quality of the health services and to assist service provider and managers to use the data at the service delivery level.
- To assess the progress of district health programs.
- To help districts in preparation of work plan.

- To provide feedbacks on achievements, coverage, continuity and quality of health services to hospitals and district public/ health offices.
- To publish a comprehensive Annual Report of RHD of Health Services
- To conduct Regional Performance Review of health programs and support to regional and district level reviews.
- To establish health information bank at the regional level.

Strategies

- Collection of information from all levels of service delivery institutions, analysis and use for planning, monitoring and management.
- Initiate bottom-up planning.
- To organize programme performance review meeting.

6.8.2 Major activities

- Preparation, printing and distribution of Annual Report of FY 2069/70 (2012/2013) of Regional Health Directorate (RHD) and DHOs/DPHOs.
- Regular periodic review meeting of RHD and DHO/DPHOs conducted.
- Integrated supervision to health facilities, training and orientation to health workers.
- Construction of PHCs, HPs, birthing centers, store building, staff quarters, and birthing units is being continued.
- Health Facility Up-gradated and given approval to Private Health Facilities.
- Monthly reports are monitored regularly and feedback given to the concerned agencies.
- Data verification and district level Planning, monitoring and Review meeting.
- Annual work plan and supervision plan was prepared by districts and region based on the evidence based information.

Table 31: Sources of Information in Eastern Development Region, FY 2071/72

Institution	Number	Institution	Number
Zonal/Districts/ Others Hospital	19	EPI clinic	3807
Primary Health Centre	49	FCHV	10876
Health Posts	863	I/NGO	69
Sub Health Post	0	Private health	218
PHC-ORC	2919	institutions	

Altogether 19 Government hospitals (district hospital 13; Lahan, Rangeli and Katari hospitals-3, and Zonal hospitals - 3), 49-Primary health care centers, 863-Health posts, 218 - Private health institutions and 69-non-governmental health facility, one 700-bedded tertiary care center (BPKIHS), 10876 FCHVs were the sources of information as shown in the table.

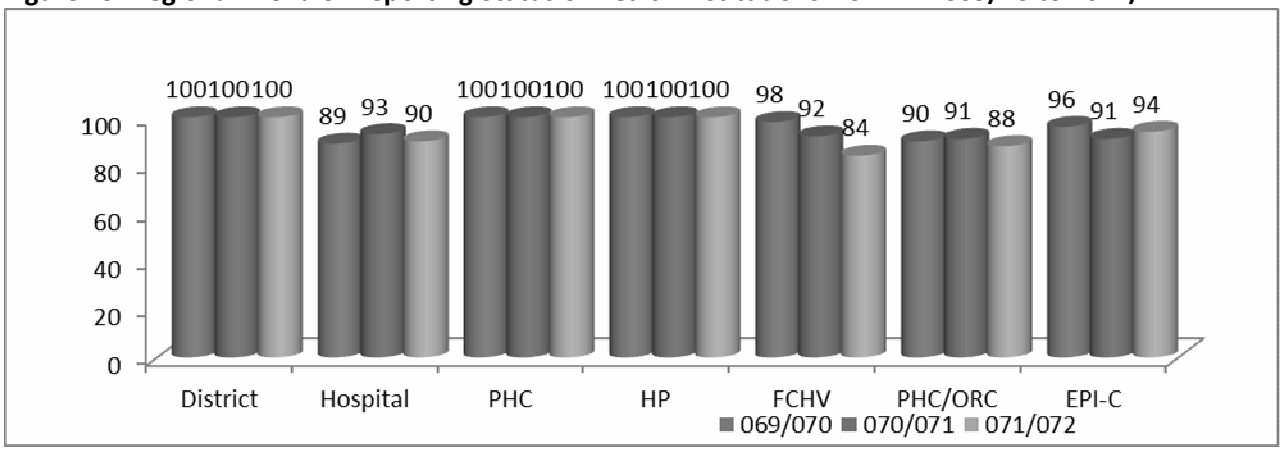
6.8.3 Analysis of Achievement

Table 32: Reporting Status by Health Institutions, FY 2071/72

Districts	Hospital	PHC	HP	FCHVs	PHC/ORC	EPI-C
Taplejung	70	100	99	78	80	90
Panchthar	100	100	100	81	87	88
Ilam	100	100	100	77	94	97
Jhapa	100	100	100	82	83	102
Morang	100	100	100	84	88	93
Sunsari	100	100	100	78	93	96

Dhankuta	100	100	100	84	82	90
Teharthum	100	100	100	88	88	92
Sankhuwasabha	100	100	100	80	83	91
Bhojpur	100	100	100	93	79	98
Solukhumbu	100	100	100	85	82	87
Okhaldhunga	100	100	100	87	111	93
Khotang	100	100	100	86	89	95
Udaypur	100	100	100	85	90	95
Saptari	100	100	100	94	91	97
Siraha	100	100	100	91	79	91
Region	**95**	**100**	**100**	84	88	94

Figure 29: Regional Trend of Reporting Status of Health Institutions from FY 2069/70 to 2071/72



The Figure 29 shows the reporting status of health institutions, which has been changing over three years except districts'. The reporting status of Hospitals is fluctuating and decreasing than previous FY 2070/71. Reporting status from HP, PHC, remained 100% and static since the last three years.Reporting status of FCHV shows decreasing trend.

Table 35: Number of ambulance available in districts

S N	Districts	No.of Ambulance	
		Registered	Functional
1	Bhojpur	4	3
2	Dhankuta	6	6
3	Ilam	11	10
4	Jhapa	111	111
5	Khotang	4	3
6	Morang	97	93
7	Okhaldhunga	5	4
8	Pancthar	14	14
9	Sankhuwasava	5	4
10	Saptari	12	12
11	Siraha	33	29
12	Solukhumbu	3	2

13	Sunsari	-	-
14	Taplejung	8	7
15	Terhathum	5	4
16	Udayapur	21	19
Total		**339**	**321**

6.8.4 Issues, Problems/Constraints and Actions to be taken

Major Achievements	Performance gaps	Causes/reasons	Recommended actions for improvements
Web based HMIS	Not implemented bottom up planning	Planning process is not effective (not based on evidences) in the first quarterly review and planning meeting	Provision of competent facilitators and need of tools (Use of health planning guideline), Use of District Population Profile for health planning, Compulsion of preparation of plan, reward system and focus on evidence based planning
Reporting from Reporting status from HP, PHC remained 100%	Reporting status from private and NGO sector	Low reporting status from NGOs and Private Health Institutions	Update profile of I/NGOs and private sectors, regular monitoring and supervision, follow of rules and regulations

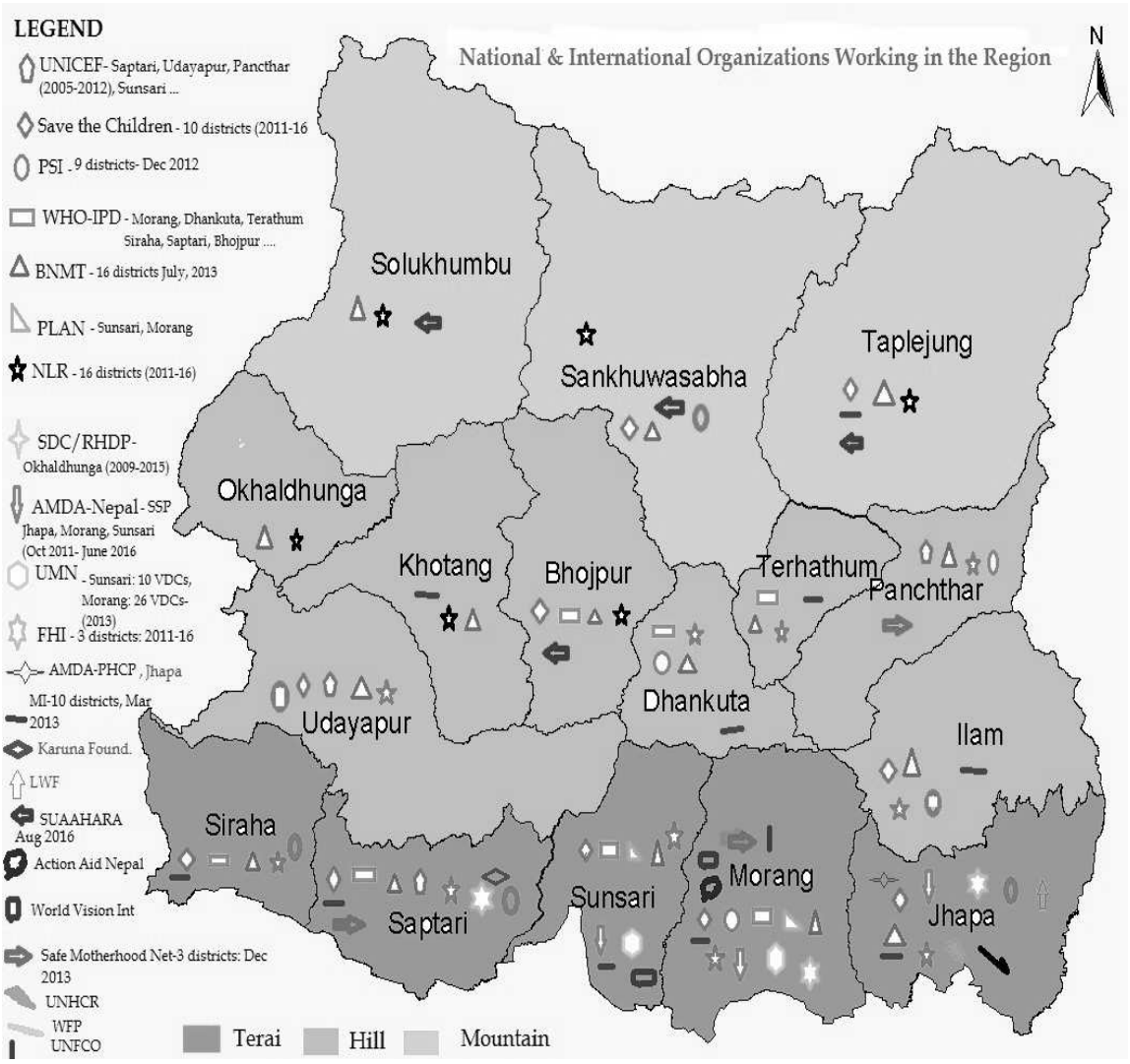
7. DEVELOPMENT PARTNERS

The outcomes discussed in the previous chapters is the result of combined efforts of ERHD-MOHP and the development partners (multilateral, bilateral organizations and international and national NGOs). ERHD highly acknowledges partnership with these organizations and their contribution.

Table 36: Name of organization with their areas of intervention

SN	Name of Organizations	Area of Intervention
2	**UNICEF (Eastern Region Office)**	Child Health, Maternal & Newborn Health, HIV & AIDS, Education, WATSAN, Governance
3	**WHO-IPD)**	Child health: Immunization
4	**Plan Nepal**	Strengthen existing health system, Medical and Surgical Treatment Support, Treatment support for Disabled children
5	**AMDA-Nepal**	STI & HIV
6	**Netherlands Leprosy Relief (NLR)**	Leprosy control and disability management through CBR strategies and right based approach, Inspire2Care, Disabilities Inclusive Relief & Rehabilitation, WASH/NTD
7	**UMN, Nawa Jiwan Samaj Sewa Itahari**	HIV and AIDS, Community Health and HIV and AIDS
8	**Save the children**	Health, Adolescent development, MNCHN, HRH, Nutrition, Livelihood, Education, HIV, CRG, Protection, Gender norms and disaster
9	**The Britain Nepal Medical Trust (BNMT)**	Health; Livelihoods; and effects of Climate Change, Environment, Disaster on Health; and Peace Building. EDR level: TB control programme, Rehabilitating Children Project for conflict affected and RBA for DAG Communities.
10	**FHI 360 Nepal**	HIV, Reproductive health and Capacity enhancement.
11	**PSI**	Promoting the use of long-term methods of contraception, expanding access to quality medical abortion products and services, particularly through private sector service providers and social marketing
12	**IOM**	Bhutanese refugee operation, livelihood, income generating activities
13	**Karuna Foundation**	Essential Community Health Services and awareness raising activities for the prevention of avoidable disability, Community Based Rehabilitation
14	**World Vision**	Maternal & child health, HIV/AIDS
15	**Action Aid Nepal**	Health, education, food security and women's rights
16	**Safe motherhood Network**	Safe motherhood and other RH initiatives, women empowerment
17	**UNHCR**	Care & maintenance to Bhutanese refugees, support to surrounding host communities for strengthening health and education activities through its partners
18	**WFP**	Food and nutrition
19	**UNFCO**	Humanitarian affiars, Emergency preparedness & response
20	**Micronutrient Initiative**	Micronutrient supplementation support (Vit A, Zinc, Iodine, Iron & folic Supplementation) to GoN, Health System strengthening
21	**Nepal Health Sector Support Program**	Strengthening Planning, Monitoring and Evaluation, Health Sector Information and Coordination System

Figure 30: Map of National and International Organizations Working in the Region



7.1 POPULATION SERVICE INTERNATIONAL (PSI) Nepal

Introduction:

PSI, a non-profit organization began operations in Nepal since 2002 with social mission to encourage healthy behavior through its social marketing health programs. PSI, headquartered in Washington DC, was founded in 1970 and currently distributes affordable, accessible, and attractive health products and services in more than 60 countries. PSI raises awareness of health problems through innovative and culturally sensitive communications and generates demand for the health products and services it provides. PSI's primary interventions concern: family planning, HIV/STI prevention, diarrheal disease, malaria, micronutrient deficiencies, and waterborne illnesses. PSI takes a comprehensive approach to sustainable development, working in support of local governments and ministries of health and in partnership with local organizations to help reach nationally developed health objectives. Harnessing the power of private markets and local economies, PSI delivers life-saving messages, services and products to the world's most at-risk populations worldwide. Through partnership with local organizations, PSI provides the dignity of choice to vulnerable communities.

Women's Health Project (WHP):

Under the current Phase 3 of the WHP, PSI/Nepal will support the Government of Nepal's (GoN) efforts to reduce maternal mortality rate (MMR) and increase contraceptive prevalence rate (CPR). PSI/Nepal will contribute to the national health goal of reaching CPR to 67% by 2015 by increasing availability and use of IUD from 1.3% (2011) to 3.7% in 2015. PSI/Nepal will support the MoHP and the private sector to increase access to safe abortion care by distributing 125,736 medication abortion (MA) packs.

Major program components include training of private sector providers in delivery of IUCD services, implementing an Inter Personal Communications (IPC) and Behavior Change Communication (BCC) program to inform women of reproductive age and generating demand for IUCD services, and expanding IUCD and MA services in the public sector. PSI/N also focuses on developing quality of care provided to target population. In order to ensure that providers meet minimum quality standards, coaching and supportive supervision visits are conducted by senior providers (coaches) to assess service delivery quality, provide feedback and recommend for further refresher training or action plan if required. In order to manage possible cases of adverse events and complications, PSI/Nepal has established contract with 60 referral sites across the country.

Malaria Project:

Malaria continues to be one of the prioritized public health programs of the Government of Nepal (GoN). Development partners have been playing pivotal roles in augmenting the Government of Nepal in mitigating the burdens of malaria. This public-private partnership (PPP) has paid dividends: Nepal has achieved the Millennium Development Goals (MDG) in malaria control well before the timeline specified. There has been a continuous decline in malaria burden every year. Capitalizing on the success achieved so far, PSI/Nepal jointly with the GoN aim to work towards achieving the pre-elimination stage and then make Nepal a malaria-free nation by 2026.

Since the dawn of The Global Fund to Fight against AIDS, Tuberculosis and Malaria (GFATM) support in malaria, PSI/Nepal has been working hand in hand with the Epidemiology and Disease Control Division (EDCD) of the Department of Health Services, Ministry of Health and Population since 2006. Collaborative efforts with the World Health Organization (WHO) have also remained instrumental in achieving progressive results.

PSI/Nepal has been implementing the preventive aspect of the malaria control program. Major components of its programs include the distribution of long lasting insecticide-treated nets (LLINs), training to private sector health service providers (PSHSP), and behavior change communication (BCC) messages at household level, school-based behavior change communication program and household survey to evaluate program impact.

Project Coverage

Currently, PSI/Nepal's Women's Health Program is operational in fifty districts throughout the country. In the eastern region, the project is functional in nine districts (Dhankuta, Illam, Jhapa, Morang, Saptari, Siraha, Sunsari, Terhathum and Udaypur) under its Sector Office at Biratnagar

7.2 The Britain Nepal Medical Trust

BNMT Nepal (Birat Nepal Medical Trust)

BNMT Nepal is built on the foundation of Britain Nepal Medical Trust UK with commendable history of serving the people of Nepal since 1967. It supports the Government on maternal & child health, nutrition, TB, other diseases and relief works. Its work covers strengthening the capacity of local institutions in responding to community health needs; empowering disadvantaged communities in accessing health services; and developing innovative approaches for affordable quality health services.

Programme Interventions:

Post Disaster Management Initiative

Community Water, Sanitation and Hygiene (WASH) Programme: BNMT had constructed four permanent gender segregated four compartment community in the affected internally displaced populations of Bhaktapur and Lalitpur. Different WASH kits, water purifier and sanitary napkins were distributed to the internal displaces community and school children of Bhaktapur and Lalitpur. WASH committee were formed and the toilets were handed over to the municipality and the committee of the construction site.

Mental Health and Psychosocial Support Programme (MHPSS):

BNMT Nepal had provided technical & financial support to District Public Health Office (DPHO) Kathmandu for Psychosocial Support Program. A rapid community based needs assessment on psychosocial conditions in the earthquake affected districts was carried out and more than 2000 people including pregnant and lactating women were provided psychosocial support and counseling services in Kathmandu, Makwanpur and Bhaktapur. The Psychosocial services had tremendous positive effect on the target group. BNMT Nepal also conducted trainings on Post- Disaster Psychosocial Counselling and Support to various NGOs, health workers, female community health volunteers, teachers, students and community.

Distribution of Relief Materials

Thousands of affected households of Sindupalchok, Nuwakot, Kathmandu, Bhaktpur and Lalitpur, received relief package like tents, tarpaulins, blankets and clothes including essential food items.

Conducting free health camps and distribution of essential medicines

More than twenty one hundred individuals from different districts like Kathmandu, Nuwakot, Dhading, Sindhupalchowk, Kavre and Makawanpur have benefited from various free health camps held on separate occasions. Essential medicines were distributed free of cost to the needy and earthquake affected people.

Essential medicine provision to Government of Nepal and other local agencies:

BNMT Nepal has supported essential drugs (worth approximately 500,000 US$) support to Logistic Management Division, MoHP for earthquake affected districts. BNMT Nepal also provided essential drug support to Sisdole Health Post, Nuwakot,

and Baramchi Health Post in Sindhupalchowk. Oncology ward of Kanti Children Hospital has also been one of our beneficiaries. Likewise, BNMT Nepal also supported National Institute of Neurological & Allied Sciences (Neuro Hospital) Bansbari and Tamakoshi Cooperative Hospital in Ramechhap to conduct health camps in the earthquake affected areas in Gorkha, Sindhupalchowk and Ramechhap districts respectively.

Management of the Eastern Region TB Quality Control Centre

BNMT Nepal manages the Eastern Region Quality Control Centre (ERQCC). The ERQCC is located within the Nepal Anti-Tuberculosis Association (NATA) Morang premises in Biratnagar. The Government of Nepal is responsible for overall guidance, monitoring and supply of logistics. BNMT Nepal is responsible for providing the human resources as well as being responsible for the Quality Assurance of TB Microscopy for the Eastern Region. The ERQCC helps to improve the cost-effective manner in which services are utilised as well as reducing errors by promoting uniformity in the process used and maintaining these standards. It helps to reduce and minimise the waste that occurs in the process of TB microscopy. In the long run it helps TB Control for Quality and Sustainability of services.

- Blind Re-checking: Blind re-checking is a method of checking randomly selected sputum smear slides from the routine workload at a peripheral laboratory (the "test" laboratory) which is re-examined at an intermediate or reference laboratory (the "control" laboratory) showing details of incorrect scorings and offering corrective actions to ensure the standard of quality of sputum microscopy for TB diagnosis.
- Supply of laboratory re-agents: In order to maintain the standard of the quality for TB microscopy along with the other logistics all the basic crude reagents such as sulphuric acid, carboluchsin and methylene blue are supplied by the National Tuberculosis Center (NTC) to the ERQCC.
- Capacity Building: For capacity building of the laboratory staff practical based competency trainings are being provided to the laboratory staff for the whole process of sputum microscopy for TB diagnosis and their follow up for monitoring the effectiveness of treatment.
- Supervision and Monitoring: Supervision and monitoring of the microscopy centres by the ERQCC staff with regular feedback and on the spot training for the laboratory personnel in the centres.

Post Disaster Need Assessment and Recovery Plan – National Tuberculosis program

BNMT as a partner organization supported National Tuberculosis center in carry out the Post disaster need assessment for TB in three districts: Nuwakot, Dhading, Rasuwa, among 14 earthquake affected district of Nepal. The aim of the assessment was to collect and collating information on damage, losses, tracing TB (particularly DR TB patients) and identifying post disaster needs for reconstructing and rebuilding TB services with the broader concept of building back better.

Study on Effectiveness of Integration of Family Planning into Agriculture and Economic Empowerment Program for Access and Coverage (TICA project)

TICA is an intervention being piloted by ADRA Nepal in three districts of western Nepal (Palpa, Kapilvastu and Rupandehi). This intervention seeks to assess the effectiveness of FP interventions when paired with agriculture and economic

empowerment interventions and to assess the impact of economic empowerment programmes when paired with family planning.

BNMT Nepal has conducted the pre and post -intervention study of the TICA project. The study was conducted at five Village Development Committees (VDCs) in each of the three districts where ADRA Nepal's other project Develop Local Economy to Eradicate Poverty (DEEP) was implemented in 2014.

Menstrual Hygiene Management (MHM)

BNMT Nepal launched a pilot project on MHM in three public schools namely Shree Durga Higher Secondary School, Majhare; Shree Prajatantra Secondary School, Bhaudaha and Shree Arniko Higher Secondary School, Rajghat VDCs of Morang district from January to May 2015. The main objective of the project was to promote adolescent girls' rights to reproductive health through Menstrual Hygiene Management.

The project was successful in increasing the level of understanding among students of their physiology and has changed their perceptions on menstruation. It has enabled the young girls to properly manage menstrual hygiene and have created a preference and need for home made sajilo napkins. One of the most striking issues that came up was the lack of toilet facilities for girls in the school, which is essential for good MHM. BNMT Nepal plans to scale up the project to reach wider most at need communities to address one of the key elements "sexual and reproductive health rights of young girls" through menstrual hygiene management.

7.3 Netherlands Leprosy Relief (NLR), Nepal

Introduction of the program/Organization

NLR is a non-profit, non-religious INGO which was established in 1967 as a private initiative initially supporting leprosy control activities in Tanzania and Nepal. NLR has been supporting projects in Nepal since 1977, initially focused on the construction of health facilities and leprosy control. Since 1986 NLR have been working exclusively on leprosy control and community-based rehabilitation, maintaining a focus on persons with disabilities due to leprosy. NLR has recently broadened its support to general disability regardless of cause, though the nucleus of our work remains disabilities caused by leprosy.

In Nepal, leprosy control activities are carried out directly through the Ministry of Health and Population with financial support from NLR through Government Redbook system. NLR maintains a strong partnership with the government health network via leprosy control division. Over the years, NLR has helped to create a strong network of governmental, non-governmental and civil society organizations, especially in the area of disease control, disability management and CBR. This important bridging position among different sectors in the society will remain a major focus in future. In the area of disabilities management, NLR partners with the National Federation of Disabled Nepal (NFDN), as well as its member organizations, DPOs, and CBR organizations. NLR is a member of the Association of International NGOs (AIN) and the Nepal Leprosy Network (NLN).

NLR is working to combat leprosy and its consequences, but there is still a large unmet leprosy-related rehabilitation need in the country. It has been experienced that successful POD and rehabilitation activities increase the credibility of the program, which in turn promotes earlier self-reporting and better treatment compliance. The most significant recent development is the ratification of the UN Convention on Rights for People with Disabilities by Nepal on 7th of May 2010. The other major development is that WHO Disability and Rehabilitation Team (WHO/DAR) indicate the increased global attention for the needs of persons with disability and the new CBR Guidelines are developed through a global participatory process and launched in Nigeria in October 2010. With the long experiences of disease control & disabilities, NLR, to adopt such evaluations, has made transformational shift from medical, charity to rights based approach, in its strategic and implementation stages.

NLR, with a Country Representative Office in Kathmandu established in 2006, provides technical and other supports through two field projects, one in Eastern Region (established in 1979) and the other in Far Western Region (established in 1991). These directly cover 25 (16 in Eastern Region and 9 in Far western Region) of Nepal's 75 districts. Objectives for this project period (2010-2015) are as follows;

General Objective of the project:

To support the GON in further reducing the burden of leprosy and providing assistance for the rehabilitation of persons with disabilities mainly due to leprosy so that they will be able to lead a normal healthy life in their own families and communities

Specific objectives of the project:

- Leprosy burden reduced in the project area through provision of quality services
- Effective rehabilitation services established and utilized through multi sectorial approaches and in partnership with other stakeholders in NLR-supported areas: i.e. Far Western and Eastern Regions of Nepal

Major achievement of the last fiscal year

NLR has provided financial as well technical support to GON, NGO, DPOs, Civil society organizations & CBR organizations aiming to achieve two major overall goals; a. Reduce burden of leprosy aiming to achieve leprosy free society in future and b. Ensure equal opportunities, equal rights & barrier free environment for PWDs aiming to achieve inclusive societies with inclusive development. In this regard following are the major achievements of the past fiscal year;

- Leprosy elimination that achieved a few years back is continually sustained with declining disability due to leprosy (DG II) and child cases
- Social stigma due to leprosy has been continually reducing with the inclusion of affected to different mainstreaming development programs
- Integration and reversal integration are well promoted with the provisions of mainstreaming leprosy to general disabilities and vice versa
- Discrepancies, discrimination & injustice for affected persons as well persons with disabilities are minimized with the proper networking, advocacy & lobbying mechanisms that established at different levels
- Better opportunities are created for PWDs & other affected persons on their rights including human rights as well as the socio economic & cultural rights with the promotion of implementation and realization of UNCRPD
- Strong partnership between the related stakeholders is sustained and promoted to ensure on achieving the thematic objective of “No one left behind” from the mainstream of overall development prospective.
- LPEP (Leprosy Post Exposure Prophylaxis) as a new technology introduced in three districts of Nepal to prevent leprosy in the higher risk groups
- Improvement of Maternal & Child health program indicators in the Inspire2Care program (disabilities prevention & management) implemented areas
- Disabilities inclusive development initiations with the target of “Built back better” in disaster related program areas
-

Future plans for the current fiscal year

NLR has adopted new scientific tools for P M & E, that is called “Outcome Mapping” and hence support strategies will be done accordingly but the supports for the major activities as mentioned herewith will remain continue. Early case detection, awareness rising, capacity building of health workers and related stakeholders, complication management, surgery, physiotherapy, assistive & protective devices will remain the core activities in the field of disease control and health where as networking, advocacy, lobbying, promotion of iclusive education, vocational skill development, income generation schemes, micro credit and saving schemes, promotion of equal rights, awareness rising and lobbying for service providers for better implementation of existing GON provisions, capacity building of right holders on: their rights, good governance, management are the main activities to promote Community Based Rehabilitation.

Training, capacity building, networking, supervision and monitoring will remain the mainstay of supportive activities. Such activities are necessary to ensure that patient care (comprising case finding, case holding and the prevention of disabilities - POD) in all health facilities

is of good quality, adequately addressing the needs of the persons. The approach to leprosy control be differentiated; areas with high patients load needing more intensive support in training, supervision and monitoring as well as support to the referral centers than areas with fewer patients and thus reduced staff training & supervision needs. In the rehabilitation component of the project, main supporting activities will be in capacity building of the persons with disabilities, DPOs, CBOs, NGOs as well as GON officials and networking with the duty bearers of different services in GON as well as non-government sectors. Comprehensive WASH related activities aiming to reduce NTDs will be promoted and some of the villages will be transformed to “Disabilities Friendly Model Villages”.

7.4 Action Aid International Nepal -Eastern Resource Center, Biratnagar

Introduction:

After ten years of its establishment as a charity organization in the United Kingdom, ActionAid started working in Nepal in 1982. Based on the learning from its engagement in various sectors at various levels from grassroots to international AAIN has evolved through various changes on approaches and working modalities in its 31 years journey of fight against poverty and injustice. Starting from charity-based work to improve the basic living conditions of the poorest people in the 1980s, now AAIN has adopted a human rights-based approach with an aim to enhancing the poor and excluded people's capacity to claim and exercise their rights to live a dignified life. Our approach reaffirms the role of popular struggles, social justice movements, popular actions, community based organization peoples organizations for rights conscientisation and transformation of unequal power relations. Action Aid International is active in over 40 countries across Asia, Africa, the Americas and Europe, with headquarters in Johannesburg, South Africa.

Vision: "A Nepal without poverty and injustice in which every person enjoys their right to a life of dignity."

Mission: "To work with people living in poverty and excluded people to eradicate poverty and injustice in Nepal."

Action Aid Nepal works with

ActionAid international Nepal commits to work with all excluded, deprived and marginalized groups such as women, dalits, highly excluded indigenous peoples and people living in poverty.

Our values are:

- Mutual respect and humility Equity and justice, honesty and transparency
- Solidarity with the poor Courage of conviction Independence
- Gender sensitivity

Objectives:

1. Ensure improved livelihoods and build disaster resilient communities by enabling people living in poverty (PLiP) and marginalised people to claim productive resources.
2. Facilitate political advancement of PLiP marginalised people to hold duty bearers to account, develop propositions for national development strategies and deepen democracy.
3. Objective 3: Engage with women and girls to build their active agency to challenge and take action against all forms of discrimination and injustice against their body, sexuality and unequal burden of work
4. Support all children to attain quality education in a safe and equitable environment

Partnership with (Eastern and Central Region – Managed by Biratnagar Office, AAIN)
ActionAid international Nepal is implementing Local Rights Programme (LRP) partnering with local nongovernmental and civil society organizations. Besides LRP some projects are also implemented in some districts.

7.5 FHI 360 Nepal

Background

FHI 360 is an international non-governmental organization that has been operational in Nepal since 1993. It has been implementing project to support National HIV response through the financial support from United States Agency for International Development (USAID). Currently, FHI 360 Nepal is implementing USAID-funded Saath-Saath Project (SSP) (2011-2016) which builds on the invaluable contributions made by previous USAID-funded projects to support National HIV response. The goal of the project is to reduce transmission and impact of HIV & AIDS and improve reproductive health (RH) among selected key affected populations (KAPs) in a manner that supports the Government of Nepal (GoN).

The project works in partnership with Government of Nepal's Ministry of Health (MoH) through National Centre for AIDS and STD Control (NCASC), Family Health Division (FHD), Logistics Management Division (LMD), National Health Training Center (NHTC), National Public Health Laboratory (NPHL) and National Health, Education, Information and Communication Center (NHEICC). All SSP activities contribute directly to Nepal Government's National HIV and Family Planning responses and USAID Nepal's Country Development Cooperation Strategy (CDCS) Development Objective 3 Increased Human Capital and intermediate result 3.2 A Healthier and Well Nourished Population.

Areas of Intervention

- HIV prevention,
- Sexually Transmitted Infections (STIs) diagnosis and treatment,
- Voluntary HIV counseling and testing (VCT),
- Essential package of care services (EPC) {pre-antiretroviral therapy (ART)} for PLHIV,
- Family Planning (FP) counseling, services and referrals,
- Gender-Based Violence (GBV) prevention education and referral, and screening, psychosocial counseling, treatment and referral services for GBV cases,
- Community and Home-Based Care (CHBC) and Positive Prevention for PLHIV and their families,
- Research, Surveillance, Monitoring & Evaluation,
- HIV-related stigma and discrimination reduction and
- Capacity strengthening.

Beneficiary Groups

- Female Sex Workers (FSWs)
- Clients of FSWs
- PLHIV and their family members
- Transgender Sex Workers (TGSWs)

Geographical coverage

FHI 360 Nepal through SSP is implementing its activities in 33 districts across the country. In Eastern Development Region, SSP is working through three implementing NGO partner agencies in three project districts which are Jhapa, Morang and Sunsari.

Details of the NGOs along with their coverage districts, major activities and target groups are as mentioned below:

SN	Name of NGOs	Major activities	Target Groups	Districts
1	Association of Medical Doctors of Asia – Nepal (AMDA-Nepal) (SSP Core Partner)	STI diagnosis & treatment, VCT, Pre-ART, FP and GBV prevention and mitigation	FSWs and their clients and PLHIV	Jhapa, Morang and Sunsari
2	Sahara Nepal	HIV and STI prevention, GBV prevention and mitigation	FSWs and their clients	Jhapa, Morang and Sunsari
3	Dharan Positive Group (DPG)	CHBC, Positive Prevention and FP information and referral	PLHIV and their families	Sunsari

Summary of the program achievements on key indicators in Eastern Development Region (August 2014-July 2015)

Key Indicators	Achievement
Number of people reached through HIV prevention *(FSWs, Clients of FSWs and PLHIV)*	9,890
Number of individuals examined for STI	2,187
Number of individuals who received HIV test results after post-test counseling	2,161
Number of individuals received FP screening	1,781
Number of PLHIV reached with palliative care and support service	470
Number of Condoms distributed	820,800
Number of people trained in HIV-related stigma and discrimination reduction	973

Reporting period: November 2015 – January, 2016

Region: Eastern

Districts covered:

1) Jhapa
2) Morang
3) Sunsari

Name of implementing agencies:

1) AMDA
2) Sahara Nepal
3) Dharan Positive Group

Beneficiary groups:

- Female sex workers (FSWs) and their clients
- People living with HIV (PLHIV)
- Transgender sex workers

Types of activities:

- HIV and STI prevention.
- Gender Based Violence (GBV) prevention and mitigation services in Sunsari district
- Positive Prevention in Sunsari district.
- Community and Home Based Care (CHBC) in Sunsari district.
- Expanded Integrated Health Services
    - Sexually Transmitted Infection (STI) diagnosis and treatment services
    - Voluntary counseling and testing (VCT) services
    - Essential package of care (EPC) for PLHIV such as pre –ART and basic health care services
    - Family Planning (FP) services and referral, screening, psychosocial counseling, treatment and referral services for GBV in Sunsari district

Key achievement:

Key Indicators	Male	Female	Other	Total
Number of people reached through HIV related outreach contacts	5,158	1,868	1	7,027
Number of people received STI examination	406	485	1	892
Number of people received VCT results with post-test counseling	401	441	-	842
Number of PLHIV received palliative care	258	194	1	453
Number of people received training on Stigma & Discrimination reduction	198	225	26	449
Number of condoms distributed (pieces)				206,660

7.6 Ipas/Nepal

1. Organizational Vision/Mission, goals and objectives

Mission:

Ipas is a nonprofit organization that works around the world to increase women's ability to exercise their sexual and reproductive rights, especially the right to safe abortion. We seek to eliminate unsafe abortion and the resulting deaths and injuries and to expand women's access to comprehensive abortion care, including contraceptive and related reproductive health information and care. We strive to foster a legal, policy and social environment supportive of women's right to make their own sexual and reproductive health decisions freely and safely.

Goal:

- To improve and advance women's sexual and reproductive health and rights in Nepal

Purpose:

- To enhance the ability and rights of women, including young women, to obtain comprehensive abortion care and prevent unwanted pregnancy

2. Major activities carried out in FY 2071/72

National Level:

- Assisted DoHS, MoHP to increase access of MA services in 247 health facilities in 15 districts, and 2nd trim services in 22 hospitals (6 districts in eastern region)
- Trained 152 ANMs for Medical Abortion services and 9 Ob/Gyn & MDGPs for 2nd trim services
- Oriented 3803 FCHVs on safe abortion services and strengthened referral
- 13,989 women received safe abortion services from Ipas supported health facilities
- Among the total women who received safe abortion, 80% women accepted any kinds of post abortion contraceptives

District Level:

- Ipas is supporting in 6 districts (Illam, Morang, Sunsari, Siraha, Saptari, Pancthar)
- Supported health facilities to ensure minimum requirements
- Conducted SAS training to doctors and nurses
- Implemented COPE approach to improve quality services
- Provided onsite/offsite coaching, updates to service providers
- Orientated service providers for youth friendly services
- Orientated FCHVs for referral

- Strengthened training site
- Conducted data review meeting (six monthly) and annual networking meeting

3. Constraints:

- Sustainability of services
- Human Resource gaps (transfer of trained service provider)
- Weak referral mechanism
- Unavailability of Long Acting Reversible Contraception (LARC) methods in every CAC sites
- Socio-cultural and economic barriers to receive safe abortion services and entertain Right to Health.
- Easily available of unregistered Medical Abortion drug in the market

4. <u>Future plan</u>

- Training on safe abortion and long acting post abortion contraception (Implant)
- Post training follow up, support to service providers, and health facilities
- Clinical coaching and technical updates for service providers
- Implementation of quality improvement approach in service sites
- Data monitoring and need based support
- Logistics support for quality safe abortion services
- Strengthen youth friendly services
- Data review meeting & annual networking meeitng

7.7 International Organization for Migration (IOM) Nepal, TB REACH Project

Introduction:

Established in 1951, the International Organization for Migration (IOM) is an Intergovernmental Organization working in the field of migration management. IOM was established in Nepal in 2006 AD and working mainly in various migration management activities and resettlement of Bhutanese refugees in eight different destination countries.

IOM is also implementing a TB REACH project from October 2011 in Nepal. The project is being implemented in close collaboration with the National TB Program (NTP) and aims to improve TB case detection through the use of GeneXpert technology. The project areas are entire Eastern Development Regions (EDR) and two locations of Central Development Regions (CDR) of Nepal. The project has deployed nine GeneXpert instruments in nine strategically located microscopy diagnostic centres; seven in EDR (Ilam, Jhapa, Morang, Sunsari, Saptari and Siraha) and two in CDR (Parsa and Bhaktapur). The project trained NTP laboratory staffs on the use of technology including recording and reporting.. Information on the technology is disseminated through various Information Education and Communication activities such as trainings, orientations etc. The project has also established referral mechanism from periphery level microscopic centres to GeneXpert centres through sputum transportation. The Sputum smear negative individuals with chest X-ray suggestive TB are tested with MTB/RIF assay. Additionally, the testing is extended to MDR Suspects and People Living with HIV.

Major activities:

1. Monthly monitoring visits to all GeneXpert Centers for data collection, data validation and analysis to improve the performance.
2. Regular coordination with NTP and WHO Nepal to receive guidance for the smooth running of GeneXpert Centres.
3. Capacity building of Laboratory staffs for both Public and Private organizations through trainings and workshops.
4. Quarterly evaluation and Review Workshops for dissemination of findings, lesson learned and to design strategies for further program improvement.
5. Strengthen GeneXpert Referral to increase GeneXpert testings in the centers. New locations are identified and Service is extended to periphery level health facilities.
6. Technical and logistical support to National TB Centre and Health Research and Social Development Forum (HERD) in the rollout of GeneXpert technology in other locations.

7.8 Action Contre La Faim (ACF)/Action Against Hunger

Organization Information	Action Against Hunger was founded in 1979 A.D. by a group of French intellectuals. ACF's mission consists of saving lives via the prevention of, detection and treatment of malnutrition, in particular during and following disasters and conflicts. There are 4 key pillars for ACF's programming:- • Prevention and treatment of under-nutrition • Water, Sanitation and Hygiene • Food Aid and Food Security • Advocacy
Major Health Programs Focus	NUTRITION, MENTAL HEALTH AND CARE PRACTICES • CMAM (Community Based Management of Acute Malnutrition) in Saptari
Programme Components	• Community Mobilization • Inpatient Therapeutic Care • Outpatient Therapeutic Care • Management of Moderate Acute Malnutrition (MAM)
Implementation Approach	Through partnership with DPHO
Study Design	• Cluster randomized controlled trial: the 14 existent OTPs in the district will be selected as clusters for randomization of groups based on distance of the OTPs from central point and logistic constraints. For comparison group, non-SAM children will be purposively selected from each OTP covered area.

7.9 United Nation Population Fund (UNFPA)

UNFPA, the United Nations Population Fund, is the lead UN agency for delivering a world where every pregnancy is wanted, every birth is safe, and every young person's potential is fulfilled. UNFPA expands the possibilities for women and young people to lead healthy and productive lives.

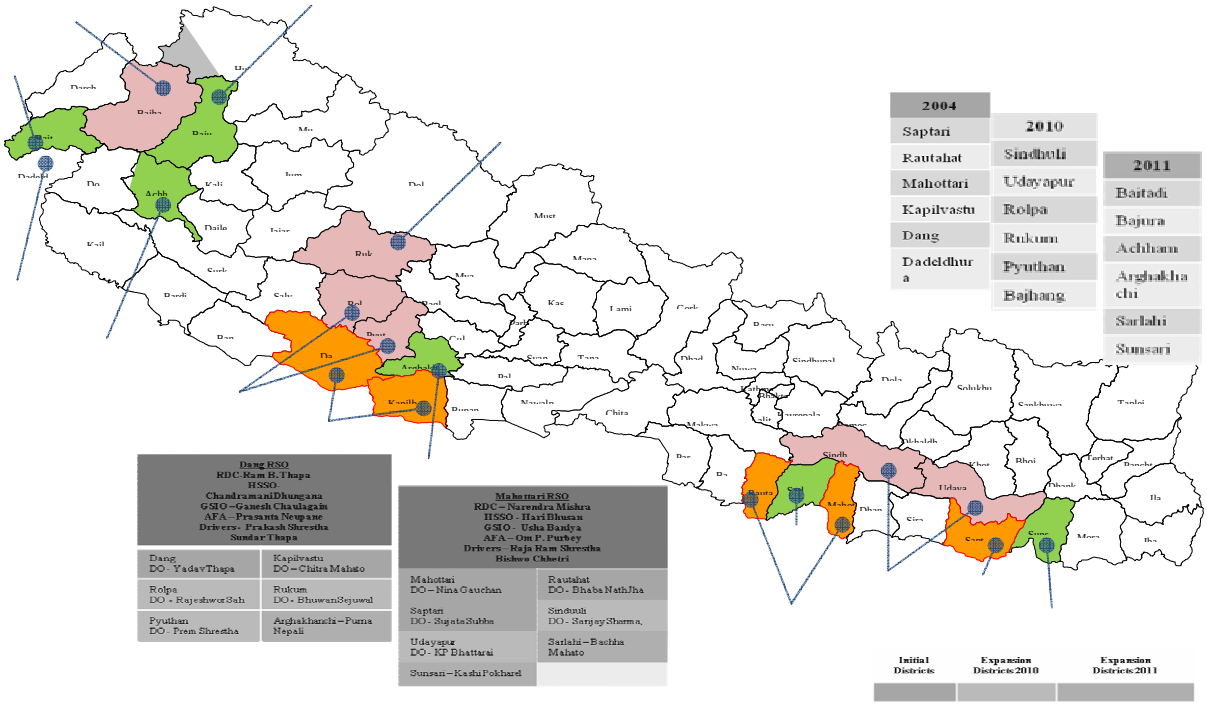
UNFPA's support to Nepal began in 1971. An evaluation of the sixth country programme, 2008-2012, cited a number of achievements. The programme helped to: (a) position UNFPA within the health-sector programme; (b) enhance the national response to gender-based violence by working with United Nations organizations and other donors; and (c) implement the population and housing census.

The current Seventh Country Programme commenced in 2013 and will end in 2017 to coincide with Government's interim development plan for 2011-13 and sectoral strategies. It will be nationally led and will employ national systems, in line with United Nations reform and in partnership with external development partners.

Area of Support:

- Young people's sexual and reproductive health and sexuality education
- Gender equality and reproductive rights
- Population Dynamics and development
- Humanitarian (Disaster preparedness and response)

Geographical Coverage



7.10 Handicap International Nepal

About Organization:

Handicap International works in situations of poverty and exclusion, conflict and disaster. In support of persons with disabilities and other vulnerable groups in 60 countries, our action and testimony have focused in the past 30 years in responding to essential needs, improving living conditions and promoting respect for dignity and fundamental rights.

The Handicap International Federation is composed of the implementation organization (Handicap International) and eight national associations responsible for fundraising (Belgium, France, Switzerland, Luxembourg, Canada, United States, Germany and United Kingdom).

Handicap International has been awarded with UNHCR **Nansen** Refugee Award in 1996 for mine clearance in Lebanon and **Hilton** Humanitarian Prize (2011) for contribution to humanitarian action in 2011 while it was the co-recipient of the **Nobel Peace Prize** (1997) in recognition of the development of Ban Landmine Treaty. Established in Nepal in 2001, **Handicap International Nepal** focuses on "**Improving the living conditions and participation of children, women and men living with disabilities in Nepal**".

HI Mission Statement:

Handicap International is an independent and impartial international aid organization working in situations of poverty and exclusion, conflict and disaster.

Working alongside persons with disabilities and other vulnerable groups, our action and testimony are focused on responding to their essential needs, improving their living conditions and promoting respect for their dignity and their fundamental rights.

Project-1: Physical rehabilitation services to persons with physical disabilities

Geographical Coverage: All districts of eastern development region through one partners
(1.) Community Based Rehabilitation Biratnagar (CBRB), Morang

Major Activities

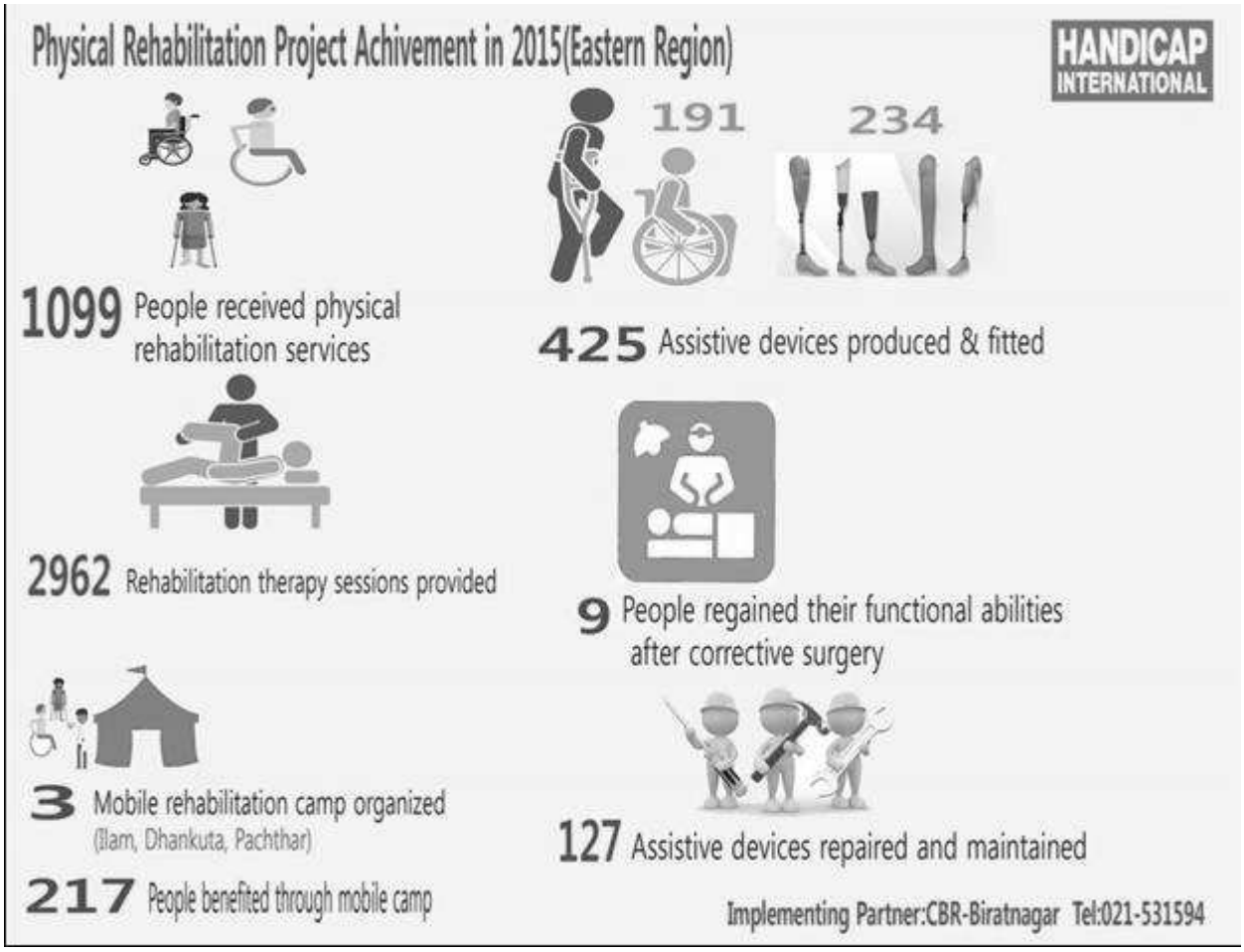
- Provision of quality rehabilitation services (Physiotherapy, Prostheses & Orthoses)
- Corrective and reconstructive surgeries through specialized hospitals/centres
- Counselling services to persons with disabilities
- Referral for other services (health, education, social, livelihood and empowerment)
- Quality assurance and capacity building (management and technical)
- Mobile rehabilitation camp

Achievements in 2015

Future Planning for 2016

- Continue physical rehabilitation services through the local implementing partners; Community Based Rehabilitation Biratnagar (CBRB), Morang
- Organize 6 events of outreach mobile rehabilitation camp
- Continue referral services for corrective and reconstructive surgeries
- Continue Community Based Rehabilitation (CBR) activities through the Community Disability Workers in 5 districts (Morang, Sunsari, Jhapa, Dhankuta and Udayapur)

- Joint collaboration with rehabilitation professional associations (NEPTA, ANOT and POS-Nepal) for the development of rehabilitation sector



7.11 Save the Children

Save the Children is the world's leading independent child's right organization with members in 30 countries and programs in more than 120 countries. Save the Children fights for children's rights and delivers lasting improvements to children's lives in Nepal and around the world. Save the Children has been working in Nepal since 1976 focusing on programs on Child Rights Governance and Protection, Education, Health and Nutrition, Livelihood, HIV and AIDS, and Humanitarian Response and Preparedness in over 69 districts of the country through four regional offices in Biratnagar, Kathmandu, Butwal and Nepalgunj.

Save the Children under Eastern Regional Office has four basic programs on health to ensure that the children survive and grow in the best possible environment and to prevent them from dying and preventable causes. We provide health services to mothers, newborn, their families and people affected by HIV and AIDS. Save the Children provides health services through Global Fund, FACT, SUAAHARA and SHN & ASRH programs that are implemented in many districts of Eastern Region.

1. **Global Fund- HIV and AIDS program:**

Global Fund program of Save the Children works in partnership with local communities to make sure children and families who have been affected by HIV and AIDS can live positively and productively without stigma and discrimination. The program strengthens local capacities to protect vulnerable children and provides care for community members infected with HIV and AIDS. Global Fund also works to address the prevention of HIV among youth by accelerating and scaling up comprehensive package of services for people who inject drugs. It also expands the access to and coverage of quality, equitable and gender-sensitive HIV diagnosis, treatment and care; and STI diagnosis and treatment; through strengthening health and community systems; scales up PMTCT by integrating and strengthening sexual and reproductive health services and also contributes to achieve the millennium development goal 4, 5 & 6 and supports to implement National HIV& AIDS strategy 2011-2016; Health Policy 2072 and Nepal HIV Investment Plan 2014-2016.

The program works in Sunsari, Morang, Jhapa, Illam, Dhankuta, Siraha and Saptari districts of Eastern Region.

Major Achievements of HIV and AIDS program in year 2015:

- 7329 People Who Inject Drugs (PWID) reached with harm reduction program
- 51 Clients reached and provided service through Social Care Unit under Methadone Maintenance Treatment Program (MMTP)
- 6333 MSM reached through comprehensive package
- 6555 labor migrants and spouses reached through outreach and peer education
- 7507 most at risk populations and vulnerable people tested and counseled, with results provided
- 858 STI cases diagnosed and treated
- 925 adults and children living with HIV currently receiving C&S services outside facilities (CHBC)
- 702 PLHIV received services from Community Care Centre (CCC)
- 95 Children living with AIDS (CLHIV) received Cash transfer service

2. SUAAHARA- Health and Nutrition Program:

SUAAHARA is an integrated nutrition project funded by the U.S. Agency for International Development (USAID), that works in 41 underserved districts in Nepal to improve the health and well-being of the Nepali people by focusing on the nutritional status of women and children under-two years of age (first 1000 days) which uniquely integrates nutrition, hygiene, agriculture, family planning, reproductive health and child health activities at the household and community level. SUAAHARA is working in close coordination and collaboration with different government stakeholders at center, region, district and community level.

The program led by Save the Children works in Taplejung, Sankhuwasabha, Solukhumbu and Bhojpur districts in Eastern Development Region of Nepal.

Major Achievements of Health and Nutrition:

- Disseminated practical knowledge on locally made different nutritious food recipes to 93,001 beneficiaries through 5,318 food recipe demonstration sessions.
- All health workers and FCHVs of 3 districts capacitated through CB-IMNCI training
- To increase the utilization of quality services from PHC/ORC, 12,822 community people were orientated through 408 events of community level interaction on PHC/ORC.
- To strengthen quality FP/MCH and nutrition services regularly to local communities residing at hard to reach geographical locations, Suaahara capacitated 4,219 HFOMC members, members of PHC/ORC management committee and HF staffs through 130 events of health facility level orientation
- With the support of Suaahara, 400 events of HFOMC monthly meetings and 628 events of FCHVs meetings were organized which supported in strengthening the local decision making and governance practice
- Provided support in days celebration (Breastfeeding Week, School Health and Nutrition Week, global hand washing day, family palnning day and Iodine month etc
- With the support of Suaahara, Seven VDCs have been declared as ODF VDC. A total of 1,494 DAG households received the sanitation materials to construct toilet.
- Community peoples learned the importance of food diversification in their daily diet specially made for 1000 days mothers

3. School Health and Nutrition (SHN) and Adolescent Sexual Reproductive Health (ASRH) :

The SHN and ARSH Program of Save the Children utilizes the school system as a service delivery mechanism; the utilization of pre-existing government structure not only reduces the cost of the intervention, but also provides a system which can be sustainable and pervasive to reach marginalized children. SHN aims to improve health and educational status of school-age children while ARSH aims to improve the health and development status of adolescents.

The program that phased out in 2015 was implemented in Siraha district of Eastern Region since 1991.

Major Achievements of SHN and ASRH program:

- 893 schools were provided with semiannual deworming

- 54 schools were provided with done health screening
- 134 event orientations were conducted to parents, mother groups on mid-day meal and reached to 4078 parents
- Hand washing facility was started in 33 schools
- toilet facility in 67 schools was made functional
- Coliform test was done in 46 schools while Arsenic test was done in 13 schools
- 93 hand pumps were installed in schools out of which 68 have safe drinking water facility
- 145 health education sessions were conducted in 43 schools
- 24 female teachers were trained in menstrual hygiene management and homemade sanitary pad.
- 49 SDPs maintained regular supply of FP commodities during last 3 months of period.
- 28279 adolescents visited health facilities.
- 4266 adolescents got RH information from teachers, child clubs and peer groups.
- 37 health facilities have flexible hours for Adolescent Friendly Services (AFS) Centers.
- 54 health workers attended service utilization sharing workshop.
- 37 health facilities adopted and applied PDQ approach at HFs.
- 50 health workers received AFS/ASRH orientation.
- 2246 adolescents and mothers participated in ANC/PNC orientation.
- 2419 adolescent girls participated in menstrual hygiene management orientation

4. The Fertility Awareness for Community Transformation (FACT):

FACT Project is a five-year United States Agency for International Development (USAID)-funded project implemented by the Institute for Reproductive Health, Georgetown University (IRH) in partnership with the International Center for Research on Women (ICRW), Population Media Center (PMC), and Save the Children (SC). FACT aims to foster an environment where women and men can take actions to protect their reproductive health throughout the life-course. As a research, intervention, and technical assistance project, FACT is testing solutions for increasing fertility awareness and expanding access to FAM at the community level, with the goal of reducing unintended pregnancies and improving family planning use.

The project works in Siraha district in Eastern Development Region.

Major Achievements of FACT program:

As the project is in the initial phase of implementation, only few activities have been conducted till date. They are:

- VDCs of Siraha district have been selected for Intervention
- Health Facility mapping of the district has been completed
- Formative Research has been completed

7.12 NEPAL LEPROSY FELLOWSHIP

Background

The Nepal Leprosy Fellowship (NLF) is a Non-Government Organization(NGO) founded in 1996 and registered at Nepal Government District Administration Office in Sunsari District, Eastern Region of Nepal. It is affiliated with Social Welfare Council(SWC). NLF works in coordination with DDC of working Districts, Regional and District Public/ Health Office in order to support the Government Leprosy Control Program in four districts i.e.; Jhapa, Morang, Sunsari, Saptari and Siraha in Eastern Terai (Plains) Region. The registered office of NLF is in Dharan, Sunsari with five field program offices from where the activities are carried out locally. There is a coordination office in Kathmandu from where government relations and organizational level coordination is done. NLF has been involved to contribute government health units in finding early cases, prevent disability and its consequences due to leprosy through ensuring completion of treatment. At present it is involved in rehabilitating leprosy affected people as well as people with disability through Community Based Rehabilitation approach for their empowerment resulting their social security and have access for their rights, ultimately to improve quality of life, for self-dependency, self-esteem, self-respect, thus spending discrimination fee dignified life.

Development objectives:

Effectively contribute to discrimination free life with dignity and socio-economic improvement of disability affected Nepalese resulted from leprosy and other causes.

Specific Objectives

1. Contribute with technical support to national leprosy program in attaining the national, regional and local goal of the leprosy control program as per national policies and regulation.
2. Provide support in caring disability affected persons who are in need of rehabilitation.
3. Raise awareness in the community to find early cases of leprosy and reduce stigma / disability due to leprosy.

Strategies

1. Agreement and permission from local DAO, SWC will be acquired and with recommendations from DPHO, approval from Regional Health Directorate Office for annual work plan will be received and all programs will be implemented in coordination with DPHO, ERHD, other related government offices.
2. Coordination will be done with DPHO, local health institution, related GO's, INGO's, NGO's and CBO's at local level for the effective services of leprosy control and rehabilitation of persons with disability.
3. Leprosy affected people and people with disability within marginalized and disadvantaged groups are facilitated for their empowerment to access their rights for health, education, social, economic development through Community Based Rehabilitation approach.

SN	Activity	Participation
1	Social Audit	District development office, District health office, Women development office, National federation of disabled Nepal, District disability coordination committee, Sankalpa CBR, Village development office ,Self help group, Local CBOs,

		Political leaders etc
2	Cooperative registered by PWDL/PWDs	Leprosy affected persons, family members of PWDLs/PWDs and other marginalized community peoples.

Out comes:

- Increased coordination level at different sector and received feedback from participants.
- Improved transparency of NLF activity.
- Improved socio-economic conditions of cooperative members due to their own cooperative.

Organizations involved:

During all the activities District Public Health Office (DPHO), Netherlands Leprosy Relief(NLR), local community based organizations(CBOs),Village Development Committees(VDCs),Primary Health Center(PHC), Health Post(HP), Sub-Health Post(SHP), National Federation of Disability, Nepal (NFDN),Sankalpa CBR, Lalgadh hospital(LH), Anandaban hospital(AH), were involved as partners.

Specially in community a VDC level **Disabled Peoples' Organizations (DPO), Self Help Groups (SHG)** have been involved in the works of leprosy and disability.

Some of the photos of NLF supported field activities at the VDCs and Health Posts within the 4 districts (Jhapa, Sunsari, Saptari and Siraha)

Cooperative members (leading by PWDL)

Community oriented activity

New case finding through self care group

Skill development activity

Issues based lobbying at

7.13 World Vision International Nepal

World Vision is a Christian relief, development and advocacy organization dedicated to working with children families and communities to overcome poverty and injustice. World vision is dedicated working with the world's most vulnerable people. World vision serves all people regardless of religion, race, ethnicity or gender. The ADP (Area Development Programme) is our primary approach to carry out transformational development, relief and advocacy work.

There are four Area Development Programmes in Eastern region namely Sunsari ADP, Morang ADP, Udayapur East and West ADP among them only three ADPs have MCHN project. ADP is long term development programme (10 to 15 years) in which World Vision works with partners and with vulnerable communities in specific, defined, targeted geographical locations to address micro and macro poverty issues in the sectors of Maternal Child Health and Nutrition, Education, Livelihood, WASH ,Sponsorship Management and Child Protection within project implementing area of Udayapur District.

Vision: - Our vision for every child, life in all its fullness

Our prayer for every heart, the will to make it so

Maternal Child Health and Nutrition Project

MCHN project Goal: Children from conception to 5 yrs and their mothers are healthy

Outcomes:-

- Improved nutritional practices for under 5 years children
- Improved health status of pregnant woman and lactating mother
- Improved childhood illness management at the households
- Increased access of community to improved health care service

Total Budget of FY 069/070:- NRs 72, 63,439 /- (Sunsari and Udayapur East ADPs only.)

Major Activities conducted in FY 071/072:-

- Enhanced practice of quality service for institutional delivery via Infrastructure and equipment support to 3 Birthing Centers and equipments support to in Sunsari & Udayapur.
- Enhanced quality service through ORC clinics via Infrastructure support to 9 ORC clinics, furniture support to 7 ORC clinics and equipment support to 26 ORCs in Sunsari & Udayapur.
- Raised Awareness level of community people on importance of 3 Es of breast feeding through wall painting in 7 places and developed and distributed of IEC materials on Nutrition , safe motherhood and child illness in collaboration with DHO

- Conducted series of trainings and orientations to FCHV , Traditional healer , HF-OMC members , Teachers as well as Mother's group member on Nutrition , Safe motherhood and childhood illness
- Day celebration such as Nutrition, Breast feeding and Iodine months in 39 different places of Sunsari and Udayapur.
- Improved nutritional status of children via super flour distribution of 229 under weight children (229 children).
- Trained youth and child clubs members of 7 VDCs on street drama and conducted street drama in different place of respected VDCs
- Established Hand washing station at 1000 Households.

Planned Budget for FY 2071/072:-

Udayapur East ADP: - NRs 64, 32,292
Udayapur West ADP: - NRs 39, 44,343
Sunsari ADP:- NRs 35,15,584
Total: - NRs 1, 42, 12,309

Planned activities for FY 2070/071

- Support to Birthing Centers , SHP/HP and ORC clinics (Infrastructure and equipments)
- Support to carry out regular growth monitoring in ORCs.
- Training and orientation to FCHV , Traditional Healer , HF-OMC members , Teachers , parents and care givers as well as Mother's group member on Nutrition , Safe motherhood and childhood illness
- Develop/distribute of IEC materials , Broadcast radio FM programme (jingle/PSA) , folk song/quiz competition, Documentary/video show on Nutrition , safe motherhood and child illness in collaboration with DHO
- Day celebration such as Nutrition, Breast feeding , Iodine months & FCHV
- Home visit by FCHV to counsel mothers on balanced diet and adequate rest during pregnancy and post partum period and check ups
- Provide super flour to Underweight children.
- Provide transportation support to the household having severe malnourished children and refer to the rehabilitation centre.
- Provide training and materials for youth club and child clubs to perform street drama on birth preparedness and child illness
- Provide trainings for HF-OMC on strengthening MCH&N
- Organize learning visit of HF-OMC members to the model HFs
- Review Meeting with HP/SHP In-charges
- Establish Hand washing station at Household level
- Provide materials support to protect the drinking water sources
- Organize campaigns at schools to promote nutritional awareness among secondary level children
- Organize refresher training to ward/village level WASH group.
- Orientation on hand washing behaviour to community people
- Provide Training of Trainers (ToT) to CLTS.

7.14 United Mission to Nepal

Established in Nepal: 1954

Vision: Fullness of life for all, in a transformed Nepali society.

Goal: Addressing the root causes of poverty leading towards fullness of life.

Thematic Area: Education, Health, Sustainable livelihood and Peace building

Working Approaches: Capacity building, Advocacy and Integral Mission

Brief Introduction of United Mission to Nepal Sunsari Cluster

Goal: People who are poor and marginalized have the capacity to live dignified and peaceful lives in a sustainable manner.

UMN Sunsari cluster established: 2004

Geographical working areas: Morang and Sunsari districts

Partner Organization: 11 (8 NGOs, 1 Cooperative,1 School & 1 Government)

No of staff: 11 (5F) & (6M)

Goal of health area:

Targeted people will practice healthy behaviour for community health, HIV / AIDS & ASRH with increased access to good quality health services (including CHBC for PLHAS).

Working location in health area of work:

- Itahari Municipality, Hasposa, Khanar, Pachknaya VDCs of Susnari
- Bhathigachha, Katahari, Bhaudaha, Soravag, baijanathpur, Patahri, Belbari, Mirgauliya, Indrapur and Sundarpur VDCs of Morang.
- 21 VACC of Morang.

Program implementing partners in health area of work:

- Nawa Jiwan Samaj Sewa Itahari, Sunsari
- Sundar Samaj Nirman Samuha Pachkanya, Sunsari
- National community Development Center Morang
- DDC Morang

Name of the health program:

- HIV and AIDS prevention and Care and Support program.
- Community Empowerment and Capacity building program.
- Community based HIV Risk Reduction Program
- Capacity building of VACC and HIV Awareness, care & support program.

Key Activities for the year 2071/72

- Group mobilization and Saving credit
- HIV and AIDS prevention awareness.
- Peer education youths
- ASRH
- MCH, FP, SRH, Nutrition and HIV awareness for group members
- Community Home Base Care for PLHIV
- Income generation activities.
- Health education for CABA.
- Support for outreach Clinic.
- Counseling training for youths.

- Capacity building of 21 VACC of Morang.
- HIV awareness and VCT refer for Spouses of Migrants
- Capacity building of PLHIV support group Morang.
- Treatment support for PLHIV
- Skill Development for group members and PLHIV
- Networking and coordination with DHOs, DACC and other stakeholders.
- Health & sanitation awareness

Major Achievements of Health Area FY- 2071/072

- 43 groups are mobilized, saving and credit and discussions on health issues in the meeting
- 5100 persons became aware on HIV transmission and preventive measures.
- 60 trained peer educators provided individual and group education for 900 peers for BBC.
- 238 youths benefited on ASRH and life skill.
- 495 group members became aware on MCH, FP, SRH and nutrition and access in health facilities.
- 75 PLHAS have improved their health condition by the CHBC, treatment and psychosocial support. Among them 40% involved in IG and increased income by Rs. 5000 to 12000 per month.
- 45 CABA have benefited on education and health.
- 609 spouses of Migrant aware on HIV and 217 refered to VCT.
- 723 received primary health care and treatment support by the clinic.
- 101 students became facilitator of 25 Schools mobilizing by VACC in school education on HIV and AIDs.
- After Health and sanitation orientation 314 members constructed toilets and using properly.
- 21 VACC of Morang review and developed plan for next year.
- Group members increased income and access in health services
- Support and cooperation provided by Stakeholders.

Future Plan for the Current Year 2071 /072:

- Given continuation of outreach clinic in 3 Village of Pachkanya VDC.
- MCH, FP, SRH and Nutrition Training for the Groups in Morang and Susari.
- HBC Care and Support for 50 PLHAs Of Sunsari
- Treatment care and support for 65 PLHAS of Morang.
- Nutrition Management training and Kitchen gardening for group memebers of MOrang and Sunsari.
- Income generation support for PLHAS and group members.
- Peer Education training and mobilization and ASRH training for youths
- Capacity building support of 21 VACC of Morang
- Awareness training and VCT Support for Spouse of Migrant in Morang.

7.15 Plan Nepal

Introduction:

Plan is an international humanitarian, child centered development organization without religious, political or governmental affiliation. Child sponsorship is the basic foundation of the organization. Plan was founded in 1937 as a "foster parents Plan" for children in battle scarred Spain: it aimed to provide food and other assistance to child survivors of the Spanish Civil War.

Plan Nepal is one of the largest organizations working with children in Nepal since 1978 to improve the lives of Nepalese children .Currently, Plan works in 13 districts directly through its partners. The name of the Program districts are: Sunsari, Morang, Makwanpur, Banke, Bardiya, Rautahat, Sindhuli, Dang, Kailali, Kanchanpur, Baglung, Myagdi, Parbat.

Focused Program (2010-2015):

Plan's work in Nepal covers 5 core areas, all of which are rooted in the rights of the child:

- Health ,Water, Sanitation and Hygiene
- Basic Education
- Household Economic Security
- Child Protection
- Child Centered Disaster Risk Management.

Future Plan of Health Program -FY-2014-2015,

- Logistic and Technical support for CBNCP Program
- Strengthening existing birthing centers by SBA training support to nurses, Clinical updates training, Clinical Equipment support, Medicine supply during emergencies
- Support for Strengthening HMIS.
- Emergency Medical and Surgical treatment support to Plan Support family (Sponsored children and their Parents, Siblings in special circumstances).
- Support during National Immunization Campaign.

7.16 NEPAL CRS COMPANY

INTRODUCTION:

CRS started in 1978 as the Nepal Contraceptive Retail Sales Project, a joint collaboration between the Government of Nepal, USAID, and Westinghouse America. In 1983, this project was converted into a non-profit company called Nepal Contraceptive Retail Sales Company Pvt. Ltd. CRS has grown steadily since 1978 and contributes more significantly each year to national family planning and public health efforts. The company has pioneered social marketing approaches and established itself as a leading public health organization in Nepal. CRS has become synonymous with family planning and its condom brand, Dhaal Deluxe, synonymous with condoms. The organization has created strong brand equity among various stakeholders and the public at-large. It now markets a portfolio of 13 products, and its sales network reaches into all 75 districts of the country. The 2011 Nepal Demographic Health Survey reported that one in four Nepalese using a reversible form of birth control and 66% of those using oral contraceptives were using CRS products.

The vision of CRS is to build a healthy future for the people of the Nepal, operating as an efficiently run social marketing enterprise implementing marketing and communication programs in collaboration with the Government of Nepal, international non-governmental organizations, national non-governmental organizations, and donors. The CRS Mission is to enable the poor and underprivileged to build a healthier future for themselves by making family planning, HIV/STI prevention, and maternal and child health products and services more accessible and conducting behavior change communication programs to create awareness and increased use of these products and services.

Nepal CRS Company
Districtwise Sales Detail
Month: August 2014 to July 2015
Eastern Region

Sales in units		Products											
S. No.	Districts	Dhaal	Panther	D'zire	S.gulaf	Nilocon Wh	Sangini	IUD	Jadelle	E-con	CDK	Nava jeevan	CYP
1	Jhapa	161,824	152,464	69,142	27,405	25,666	31,508			20,999	626	67,955	15660
2	Ilam	92,352	76,232	34,571	16,443	15,400	12,003				348	45,303	6817
3	Panchthar	57,720	33,881	15,365	5,481	8,555	1,500				348	22,652	2202
4	Taplejung	23,088	16,940	7,682	5,481	3,422	1,500				278	7,551	1366
5	Morang	184,704	194,815	88,348	32,886	32,511	36,009	15	18	18,260	487	98,157	18311
6	Sunsari	150,072	93,172	42,253	27,405	27,377	30,007			36,519	417	90,606	15359
7	Dhankuta	69,264	50,821	23,047	10,962	6,844	4,501			4,565	417	30,202	3733
8	Tehrathum	46,176	25,411	11,524	7,308	5,133	1,500			1,826	556	22,652	1988
9	Sankhuwasabha	69,264	25,411	11,524	7,308	6,844	1,500			2,739	417	15,101	2340
10	Bhojpur	34,632	8,470	3,841	3,654	3,422				913	209	15,101	909
11	Siraha	80,808	59,291	26,888	12,789	10,266	10,503			913	556	143,460	5600
12	Saptari	57,720	50,821	23,047	9,135	8,555	9,002			2,739	904	120,808	4663
13	Udaypur	34,632	25,411	11,524	7,308	6,844	6,001			913	348	45,303	3086
14	Okhaldhunga	23,088	16,940	7,682	3,654	5,133	1,500			913	487	15,101	1404
15	Khotang	34,632	8,470	3,841	3,654	3,422	1,500			-	348	7,551	1238
16	Solukhumbu	11,544	8,470	3,841	1,827	1,711	1,500			-	209	7,551	810
Total		1,131,520	847,020	384,120	182,700	171,105	150,034	15	18	91,299	6,955	755,054	85487

Eastern Region BCC target VS Achievement

Ghar Ghar Maa Swasthya (Healthy Homes), BCC/Communication activities, August 2014 - July 2015

Activities	Target Vs. Achievement
Contraceptive update training to Pharmacist	3
Achieve from Area office	3
Conduct village women group meeting	30
Achieve from Area office	30
Condom infotainment programs in hotzones	10
Achieve from Area office	11
Students orientation program on HIV/AIDS	10
Achieve from Area office	10
Organize Visibility Accessibility and Touch (VAT) event	1
Achieve from Area office	1
NTO retailer orientation program in hot zone	9
Achieve from Area office	10
HIV/AIDS orientation to MARPs	5
Achieve from Area office	2
Remaining Target	3
Street drama on HIV prevention messages	
Sangini Basic training	1
Sangini Refresher training	4

Planning for FY 2015- 2016

NEPAL CRS COMPANY
AREA OFFICE BIRATNAGAR
REGIONWISE ANNUAL TARGET FY 2015/16

Products	Mechi	Koshi	Sagarmatha	Total
Dhaal	392080	508080	249840	**1150000**
Panther	271840	379260	198900	**850000**
D'Zire	141470	191100	67430	**400000**
S.Gulaf	86346	70056	23998	**180400**
N.white	57772	58780	23448	**140000**
Sangini	57646	69700	26628	**153974**
E-con	35020	48066	15000	**98086**
CDK	720	1728	4507	**6955**
N.jeevan	118050	257350	349600	**725000**
Piyush	1000	8500	500	**10000**
Cure	600	611	275	**1486**
IUD				**200**
Jadelle				**175**

BCC Activities	Brt.	Mechi	Koshi	Sagarmatha
Number of Peopole reached with FP/RH and MCH Message				
Contraceptive update training to Pharmacist	4	1	2	1
Conduct village women group meeting	44	17	17	10
Number of people reached with HIV prevention messages				
Condom infotainment programs in hotzones	10	3	4	3
Students orientation program on HIV/AIDS	15	6	6	3
Organize Visibility Accessibility and Touch (VAT) event	4		2	2
NTO retailer orientation program in hot zone	9	2	4	3
HIV/AIDS orientation to MARPs	6	2	3	1
Sangini basic training	3	1	1	1
Sangini refresher traing	2		1	1

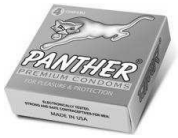
NTO - Non Treditional Outlets (Non Medical outlets)
TO - Traditional outlets (Medical Outlets)
MARP'S - Most at risk population's

New NTO opened and Resupply in Eastern region (16 districts
Period : Aug 2015 to Jul 2016

Area Office	S. No	Districts	Total New	Total Resupply
Biratnagar				
	1	Sankhuwasabha	10	69
	2	Solukhumbu	10	54
	3	Taplejung	9	58
	4	Bhojpur	25	118
	5	Dhankuta	27	136
	6	Ilam	27	131
	7	Khotang	22	106
	8	Okhaldhunga	22	130
	9	Panchthar	22	127
	10	Tehrathum	22	106
	11	Jhapa	20	192
	12	Morang	27	182
	13	Saptari	15	151
	14	Siraha	15	73
	15	Sunsari	27	219
	16	Udaypur	10	54
		Total	**310**	**1,906**

CRS's Products Portfolio:

Family Planning





Maternal & Child Health

HIV/STI Prevention

8 ANNEX

Target Population FY 2071/72

Analyzed Data

Hospital Analyzed Data