Annual Report

2075/076 (2018/019)

Health Directorate
Province No. 2

Ministry of Social Development

Health Directorate

Sapahi, Dhanusha

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Message from Honourable Minister of Social Development

I am pleased to know that Health Directorate is bringing out the annual health report of Fiscal Year 075/076., first of its kind. This report describes present health service status, major achievements, problems, challenges and programmatic opportunities of eight districts of in the province. The data, statistics, and analysis presented in this report provide us a clear picture of status of health system in the Province No.2. On the other hand, it will be a useful reference to support planning for the next fiscal year. I would urge all of us, policy makers, managers, and planners to extensively use the information presented in this report to guide our decision making at various levels of the province.

This report is result of entire team of ministry, directorate, health offices, hospitals, various health institutions and supporting agencies. I would like to extend my gratitude and thanks to all health cadres; from Female Community Health Volunteer(FCHV), health workers, managers to policy makers who have been working day and night, all year round to provide quality services at facilities and strive to improve health status of people residing in the province.

Finally, I would like to extend my sincere thanks to Health Directorate and all the key stakeholders including governmental and non-governmental agencies involved in the preparation of the report.

Honourable Nawal Kishor Sah
Minister
Ministry of Social Development
Province no 2, Janakpurdham Nepal

Preface

I believe that our stronger focus on making health services information available in public domain and its appropriate use helps us to make our health systems more transparent and accountable to people. With this gratefulness, I am pleased to release the annual report of Province Health Directorate for the years 2075/76, adding to the last many years of good practices. The Report covers all the major programmes and achievements of the PHD in the last year along with other progress in health sector in province 2 under the Ministry of Social Development. It also includes the contributions of external development partners, non-governmental organizations and private sectors in delivery of health services.

We are in initial years of implementing federalism, experiencing new development, revised structures and actors at different level. It is vital that we improve our practice towards effective use of evidence in our decision-making processes. Using information and knowledge to improve the effectiveness and efficiency of health interventions in federal context requires strengthening the links between synthesis, generation and translation of information at each level. We need to understand the strengths and limitations of our programmes, whether they are achieving high value results with efficient use of available resources. In this regard, the disaggregated information include in this report will be instrumental for federal, provincial and local governments to identify gaps in the health services delivery and to plan for provision of high-quality services in the coming years.

This report helps policy makers, programme managers and service providers in making appropriate decisions in their day-to-day practices that are evidence-based and feasible to implement. Also, useful for researchers, academics and students, as it provides an opportunity to learn and innovate new approaches to improve the health system and services in Nepal. I appreciate the hard work done by MoSD, PHD, All HO, Hospitals, Health facilities, Health workers, FCHVs, Mother Groups, EDP, INGOs, NGOs and helping hands for achieving these outcomes. Without their efforts and support, the achievement that we have accomplished today would not have been possible: they deserve our heartfelt thanks for improving health status of the Nepalese people.

Finally, I extend my sincere thanks and congratulations to the Province Health directorate, Chief of Health Division of MoSD, all section of Health and concerned personnel who contribute to this report.

Dr. Ram Prashad Ghimire
Secretary

Acknowledgement

It is my pleasure to bring the 1st Annual Report of the province Health Directorate for the fiscal year 2075/76. This report is also a reflection of annual performance of all components of health care delivery system along with their reviews conducted at various levels of health services delivery from province to palika level. It is a compilation of major activities carried out by the health institutions at all levels. The data presented in this report is based on the information submitted by the health institutions to the Health Management Information System and to other sources.

The report includes information about health care services and activities of public and private institutions providing health care to the Nepalese people. It also highlights the trend and patterns in services coverage and continuum of care. Furthermore, it also informs us about the program target and achievement with respect to budget allocation and expenditure. The report not only identifies relevant issues, problem and constraints but also suggest actions to be taken to address these issues in order to improve the services in the days to come. And most importantly this year's annual report provides the information for all three levels of government as the country has been transformed into federal structure. This imperative publication provides detailed statistical analysis of health program against its target and indicators. As this provincial level annual report will be crucial for planning and programming at central and palika levels.

I express my sincere gratitude to the Honorable Chief Minister and Minister of Social Development for Praiseworthy message. Furthermore, I would like to thank secretary and chief of Health Division of MoSD for their leadership of the overall health sector and providing a meaningful preface for the report.

I take this opportunity to offer my sincere appreciation to EDPs, INGOs and NGOs who have joined us in services delivery programs and submitting their annual activity progress report.

Finally, I hope that this report will be of great help in strengthening the health services in Province-2 and in Nepal. I also hope that it will provide validated information to all those who work for uplifting the health status of all citizens, particularly the poor and vulnerable group of the Nepali society.

Mr. Harish Chandra Sah
Director

Few Words

It is my pleasure to offer 1st Annual Report, of the Province Health Directorate for the Fiscal Year 2075/76. This report is also a reflection of annual performance of all components of health care delivery system along with their reviews conducted at various levels of health services delivery. It is a compilation of major activities carried by the health institutions at province, district and palika levels. The data presented in this report is based on the information submitted by the institutions to the Health Management Information systems and other sources.

The report includes information about the health care services and activities of public and private institutions providing health care to the province 2 Nepalese people. It also highlights the trend and patterns in services coverage and continuum of care. Furthermore, it also informs us about the program target and achievement with respect to budget allocations and expenditure. And most importantly this year's annual report provides the information for province, district and palika levels as the country has now transitioned to federal structure. This report will provide details statistical analysis of health program against its target and indicators.

I express my sincere gratitude to the Honourable Chief Minister and Minister of Social Development for praiseworthy message. Furthermore, I would like to thank secretary and Province Health directorate for their leadership of the overall health sector and providing a meaningful preface for the report. My appreciation also goes to all the EDPs, INGOs, NGOs and private health sectors for contributing significantly to improve health status of people at all concerns of the province 2 population.

I wish to place on record my appreciation and grateful thanks to all the officials of the Ministry of Social development, Province Health Directorate, Health Office of all 8 district and 136 palika level for their support and coordination. Finally, I would like to thank the Director of the province Health Directorate for the valuable services rendered in preparation and publication of this report.

Dr. Nawal Kishor Jha
Chief of Health Service division
Ministry of Social Development.

Abbreviations and Acronyms

AA	Anaesthesiologist Assistant
AAHW	Auxiliary Ayurveda health worker
ADRA	Adventist Development and Relief Agency
AEFI	Adverse event following immunization
AES	Acute encephalitis syndrome
AFP	Acute flaccid paralysis
AFS	Adolescent-friendly services
AGE	Acute gastroenteritis
AHA	Ayurveda Health Assistant
AHW	Auxiliary health worker
AIDS	Acquired immuno-deficiency syndrome
AMDA	Association of Medical Doctors of Asia
AMR	Antimicrobial resistance
ANC	Antenatal care
ANM	Auxiliary nurse-midwife
API	Annual parasite incidence
ARI	Acute respiratory infection
ART	Antiretroviral therapy
ARV	Anti-rabies vaccine and antiretroviral
ASBA	Advanced skilled birth attendant
ASRH	Adolescent sexual and reproductive health
ASVS	Anti-snake venom serum
BAMMS	Bachelor of Ayurveda and Modern Medicine and Surgery
BAMS	Bachelor of Ayurveda Medicine and Surgery,
BC	Birthing centre
BCC	Behaviour change communication
BDS	Bachelor of Dental Science
BMEAT	Biomedical equipment assistant training
BMET	Biomedical equipment training
BOPV	Bivalent oral polio vaccine
BPKIHS	BP Koirala Institute of Health Sciences
BS	Bikram Sambat (Nepali era)
BTSC	Blood transfusion service centre
EDP	External development partners
EDR	Eastern Development Region
CB-IMCI	Community-Based Integrated Management of Childhood Illness Programme
CB-IMNCI	Community Based Integrated Management of Neonatal and Childhood Illness
CB-NCP	Community Based Integrated Management of Newborn Care Programme
CBO	Community-based organization
CB-PMTCT	Community-Based Prevention of Mother to Children Transmission
CCE	Comprehensive centers of excellence
CDD	Control of diarrheal disease
CDR	Central Development region
CEONC	Comprehensive emergency obstetric and neonatal care
CHD	Child Health Department
CHX	Chlorhexidine
cMYPoA	Comprehensive Multi-Year Plan of Action
CNR	Case notification rate
CoFP	Comprehensive family planning
CPR	Contraceptive prevalence rate
CRS	Congenital rubella syndrome
CTEVT	Council for Technical Education and Vocational Training
DAMA	Discharged against medical advice
DDA	Department of Drug Administration
DHF	Dengue haemorrhagic fever
DHIS	District Health Information System
DHO	District health office
DoA	Department of Ayurveda
DoHS	Department of Health Services
DOTS	Directly Observed Treatment Short Course
DPHO	District public health office
DPT	Diphtheria, pertussis, tetanus
DQSA	Data quality self-assessment
DSS	Dengue shock syndrome
DTLO	District TB and leprosy officer
DUDBC	Department of Urban Development and Building Construction
ECC	Eye care centres
EDCD	Epidemiology and Disease Control Division
ISMAC	Iodized salt social marketing campaign
IT	Information technology

EHCS	Essential health care services
EID	Early infant diagnosis
EmOC	Emergency obstetric care
EOC	Essential obstetric care
EPI	Expanded Programme on Immunization
EQA	External quality assurance
EWARS	Early Warning and Reporting System
FCHV	Female community health volunteer
FHD	Family Health Division
FSW	Female sex worker
FWD	Family Welfare Division
FWDR	Far Western Development Region
FY	Fiscal year
G2D	Grade 2 disability
GIS	Geographic information system
GIZ	German Society for International Cooperation (Deutsche Gesellschaft für Internationale Zusammenarbeit)
GMP	Good manufacturing practice
GoN	Government of Nepal
HA	Health assistant
HFOMC	Health facility operation and management committee
HIIS	Health Infrastructure Information System
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HO	Health Office
HURIS	Human Resources Management Information System
ICD	International Classification of Diseases
ICT	Immunochromatographic test
IDA	Iron deficiency anaemia
IDD	Iodine deficiency disorder
IEC	Information, education and communication
IFA	Supplementary iron folic acid
IMAM	Integrated Management of Acute Malnutrition
IMCI	Integrated management of childhood illness
INGO	International non-governmental organizations
Ipas	International Pregnancy Advisory Services
IP V	Inactivated polio vaccine
IRS	Indoor residual spraying
IUCD	Intrauterine contraceptive device
JE	Japanese encephalitis
Kfw	Kreditanstalt für Wiederaufbau (German Development Bank)
LAMA	Left against medical advice
LAPM	Long acting and permanent methods
LARC	Long acting reversible contraceptive
LCD	Leprosy Control Division
LCD	Leprosy Control Division
LLIN	Long lasting insecticidal (bed) nets
LMD	Logistics Management Division
LMIS	Logistics Management Information System
LTF	Lost to follow-up
M&E	Monitoring and supervision
MA	Medical abortion
MAM	Management of Acute Malnutrition
MB	Multibacillary leprosy
MBBS	Bachelor of Medicine, Bachelor of Surgery
MCH	Maternal and child health
mCPR	Modern contraceptive prevalence rate
MCV	Measles-containing vaccine
MD	Management Division
MDA	Mass drug administration
MDG	Millennium Development Goal
MDGP	Doctor of Medicine in General Practice
MDIS	Malaria Disease Information System
MDR	Multi-drug resistant
MDT	Multi-drug therapy
MDVP	Multi-dose vaccine vials
MIYCN	Maternal, Infant, and Young Children Nutrition programme
MNCH	Maternal, newborn and child health
MNH	Maternal and newborn health
MNP	Micro-Nutrient Powder
MoE	Ministry of Education

MoF	Ministry of Finance
MoFALD	Ministry of Federal Affair and Local Development
MoH	Ministry of Health
MoSD	Ministry of Social Development
MPDSR	Maternal and perinatal death surveillance and response
MR	Measles/rubella
MSM	Men who have sex with men
MSNP	Multi-sector Nutrition Plan
MSS	Minimum service standard
MVA	Manual vacuum aspiration
MWDR	Mid-Western Development Region
NAHD	National Adolescent Health and Development (Strategy)
NAMC	Nepal Ayurvedic Medical Council
NAMS	National Academy for Medical Sciences
NCASC	National Centre for AIDS and STD Control;
NCD	Non-communicable disease
NCDR	New case detection rate
NDHS	Nepal Demographic and Health Survey
NEQAS	National External Quality Assurance Scheme
NGO	Non-governmental organizations
NHCP	National Health Communication Policy
NHEICC	National Health Education, Information and Communication Centre
NHIP	National Health Insurance Programme and Nepal HIV Investment Plan
NHSP-IP	Nepal Health Sector Programme-Implementation Plan
NHSS	Nepal Health Sector Strategy (2015-20),
NHSSP	Nepal health Sector Support Programme
NHTC	National Health Training Centre
NIP	National Immunization Programme
NMC	Nepal Medical Council
NMICS	Nepal Multiple Indicator Cluster Survey
NNJS	Nepal Netra Jyoti Sangh
NPHL	National Public Health Laboratory
NTC	National Tuberculosis Centre
NTP	National Tuberculosis Programme
OPD	Outpatient
OPV	Oral polio vaccine
ORS	Oral rehydration solution
OTTM	Operation theatre technique and management
PAM	Physical assets management
PB	Paucibacillary leprosy
PBC	Pulmonary bacteriologically confirmed
PCD	Pulmonary clinically diagnosed
PCV	Pneumococcal conjugate vaccine
PDR	Perinatal death review
PEM	Protein energy malnutrition
PEN	Package of Essential Non-communicable Diseases
Pf	*Plasmodium falciparum*
PHCC	Primary health care centre
PHC-ORC	Primary health care outreach clinics
PHCRD	Primary Health Care Revitalisation Division
PHD	Provincial Health Directorate
PHLMC	Provincial Health Logistics Management Centre
PHTC	Provincial Health Training Centre
PLHIV	People living with HIV
PMTCT	Prevention of mother to child transmission
PNC	Postnatal care
POP	Pelvic organ prolapse
PPH	Postpartum haemorrhage
PSBI	Possible severe bacterial infection
Pv	*Plasmodium vivax*
PWID	People who inject drugs
QI	Quality improvement
RDT	Rapid diagnostic tests
RHD	Regional health directorate
RMS	Regional medical stores
RTI	Reproductive tract infection
RTQCC	Regional TB quality control centres
SAHW	Senior auxiliary health worker

SARC	Short acting reversible contraceptive
SARI	Severe acute respiratory infection
SBA	Skilled birth attendant/attendance
SHSDC	Social Health Security Development Committee
SRH	Sexual and reproductive health
SS+	Smear positive
STI	Sexually transmitted infections
SUN	Scaling-Up-Nutrition
TABUCS	Transaction Accounting and Budget Control System
Td	Tetanus and diphtheria
TIMS	Training Information Management System
TSLC	Technical school leaving certificate
TT	Tetanus toxoid
TTI	Transfusion transmissible infection
TUTH	Tribhuvan University Teaching Hospital
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
USG	Ultrasonogram
VA	Verbal autopsy and visual acuity
VAD	Vitamin A deficiency
VBDTRC	Vector-Borne Disease Training and Research Centre
VDC	Village development committee
VPD	Vaccine-preventable disease
VSC	Voluntary surgical contraception
WASH	Water, sanitation and hygiene
WDR	Western Development Region
WHH	Welthungerhilfe
WHO	World Health Organisation
WHO/IPD	WHO Immunization Preventable Diseases
WPV	Wild poliovirus
WRA	Women of reproductive age

Health Directorate – Province No. 2

Trend of Health Service Coverage Fact Sheet

Fiscal Years 2073/74 to 2075/76 (2016/17 to 2018/19)

PROGRAMME INDICATORS	Province level			District Level (FY 2075/76)							
	2073/74 (2016/17)	2074/75 (2017/18)	2075/76 (2018/19)	Saptari	Siraha	Dhanusha	Mahottari	Sarlahi	Rautahat	Bara	Parsa
REPORTING STATUS											
% of public hospitals reporting to HMIS	85	96	97	100	100	100	100	100	88	92	100
% of primary health care centres reporting to HMIS	97	92	100	100	100	100	100	100	100	100	100
% of health posts reporting to HMIS	99	96	100	100	100	100	100	100	100	100	100
% of PHC-ORC clinics reporting to HMIS	82	83	87	96	95	83	88	81	88	80	83
% of EPI clinics reporting to HMIS	100	93	97	100	98	96	97	97	98	97	98
% of female community health volunteers (FCHVs) reporting to HMIS	94	90	94	98	94	93	95	91	95	94	93
% of private health facilities reporting to HMIS	20	18	26	63	20	23	37	15	3	19	43
IMMUNIZATION											
% of children under one year immunized with BCG	103	104	107	102	116	113	100	101	121	98	106
% of children under one year immunized with DPT-HepB-Hib3	99	87	105	97	112	136	105	90	106	100	93
% of children aged 12-23 months immunized against MR2	49	58	71	77	82	77	81	57	60	71	66
Fully immunized children	66	66	71	78	86	69	80	69	54	79	59
Dropout rate DPT-HepB-Hib1 vs 3	11	14	8	4	3	4	7	17	12	8	8
Dropout rate Penta 1 vs MR2	53	41	36	24	32	45	29	45	47	31	28
Pregnant women who received TD2 and TD2+	81	75	83	83	85	96	84	88	90	73	63
NUTRITION											
% of children aged 0-12 months registered for growth monitoring	75.1	73.5	77.6	96.1	60	67	98.8	83.5	67.6	86.5	60.7
Average number of visits among children aged 0-24 months registered for growth monitoring	1.9	1.9	2.1	2.7	2.2	1.8	2.2	1.6	1.7	2.3	2.2
% of children aged 0- 6 months registered for growth monitoring,	3.1	7.1	15.5	13.2	2.5	24.9	22.3	7.8	19.8	9.4	25.5

PROGRAMME INDICATORS	Province level			District Level (FY 2075/76)							
	2073/74 (2016/17)	2074/75 (2017/18)	2075/76 (2018/19)	Saptari	Siraha	Dhanusha	Mahottari	Sarlahi	Rautahat	Bara	Parsa
exclusively breastfed for the first six months											
% of children aged 6–8 months registered for growth monitoring received solid, semi-solid or soft foods	2.9	7.4	15.8	15.2	2.5	26.7	21.7	6.2	20.1	10.2	24.7
Percentage of children aged 0-23 months registered for growth monitoring	62.9	65.1	68	81.2	50.7	63.4	87.6	74	66.6	68.1	51.4
Percentage of pregnant women received 180 tablets Iron	42.6	45.8	56.5	64.5	108.5	34.2	68.8	52.4	58.5	33.7	34.6
CB-IMNCI											
Incidence of acute respiratory infection (ARI) per 1,000 children under five years (new visits)	472	443	498	587	693	555	322	513	336	390	326
Incidence of pneumonia among children under five years (per 1,000) Note*= HFs reporting only	58	41	38	21	51	41	48	46	52	21	26
Percentage of severe Pneumonia among new U5 yrs cases	0.3	0.3	0.3	0.1	0.2	0.2	0.4	0.4	0.9	0.2	0.5
Incidence of diarrhoea per 1,000 under five years children (new cases)	335	337	347	422	442	325	305	322	123	318	292
% of children under 5 with diarrhoea treated with zinc and ORS	94.8	97.1	102.3	96	96	97	95	94.8	98	100	90.4
% of children under five years with diarrhoea treated with IV fluid	2	1.3	0.6	0.22	0.21	0.7	0.18	1.6	0.6	0.93	0.25
Percentage of children U5 years with diarrhea suffering from Severe dehydration	0.36	0.41	0.37	0.08	0.65	0.18	0.65	0.47	1	0.28	0.32
Percentage of children U5 years with pneumonia treated with antibiotics	198.9	231.3	203	365	186	126	236	146	204	464	216
SAFE MOTHERHOOD											
% of pregnant women who received Td 2 and 2+	81.4	74.6	83.4	82.9	84.5	96.3	84.1	88.2	90.1	73.4	63.3
% of pregnant women attending first ANC visit	102.9	94.2	118.1	108	73	97	98.69	137.1	125.2	47	156.7

PROGRAMME INDICATORS	Province level			District Level (FY 2075/76)							
	2073/74 (2016/17)	2074/75 (2017/18)	2075/76 (2018/19)	Saptari	Siraha	Dhanusha	Mahottari	Sarlahi	Rautahat	Bara	Parsa
% of pregnant women attending four ANC visits	37.3	34.1	41.5	67	40.3	31	54.1	40.3	31.6	29	33.2
% of postpartum mothers who received vitamin A supplement	87.2	83.2	91.2	69.6	96.8	84.5	93.4	92.7	120.8	82.5	78.2
% of institutional deliveries	44	34	53	38	41	57	28	50	48	37	110
% of deliveries conducted by a skilled birth attendant	44	35	51	36	39	75	28	42	49	33	105
% of postpartum women received PNC check up within 24 hours of birth	43.7	33.9	45	34.4	43.1	46.1	34.2	48.1	56.8	18	82.5
% of women who had three PNC check-ups as per protocol	22.9	13.8	15.2	21.3	9.3	10.9	25.3	13.7	22.8	9	9.4
FAMILY PLANNING											
FP Methods New acceptor among as % of MWRA	8.8	8.1	8.7	9	11	8.9	6.02	8.9	7	6.2	12.3
Contraceptive prevalence rate (CPR-unadjusted)	49.4	47	49	45	49.1	40.3	44	60	48	35	64.6
FEMALE COMMUNITY HEALTH VOLUNTEERS (FCHV)											
% of mothers group meeting	99	99	95	99	96	97	102	88	93	96	91
% of PHC/ ORC conducted among planned PHC/ORC	81.9	82.7	86.9	95.9	95.1	82.3	87.5	80.6	87.8	80.2	83.3
MALARIA AND KALA-AZAR											
Malaria slide positivity rate	0.9	0.4	0.2	0.24	0.25	0.64	0.27	0.47	0.15	0.11	0.03
Annual blood slide examination rate (ABER) per 100	0.5	0.2	0.5	0.42	0.35	0.34	0.21	0.31	0.24	0.51	0.08
Annual parasite incidence (API)per 1,000	0.04	0.01	0.0034	0.00	0.0029	0.006	0.0029	0.0091	0.0037	0.0012	0.000
Incidence of kala-azar per 10,000 population at risk	0.08	0.0	0.0								
TUBERCULOSIS											
Case notification rate (all forms of TB per 1 lakh population)	109	108	114	62	92	106	119	162	107	136	137
Treatment success rate (%)	93	91	91	96	89	91	86	89	94	84	90
LEPROSY											
New case detection rate (NCDR) per 100,000 population	16	21.4	23.7	9.9	13.4	40.2	23.4	5.9	23.4	18.6	19.7
Prevalence rate (PR) per10,000	1.2	1	2.4	0.99	1.3	4	2.3	3.6	2.3	1.9	2
HIV/AIDS AND STI											
Number of HIV testing	18390	32261	42042	2902	4103	4243	7378	8029	6910	2588	5889

PROGRAMME INDICATORS	Province level			District Level (FY 2075/76)							
	2073/74 (2016/17)	2074/75 (2017/18)	2075/76 (2018/19)	Saptari	Siraha	Dhanusha	Mahottari	Sarlahi	Rautahat	Bara	Parsa
Number of new positive cases	294	368	373	6	52	70	52	74	46	31	42
% of positivity yield	2	1	1	0.2	1.2	1.6	0.7	0.9	0.6	0.7	1.2
CURATIVE SERVICES											
% of population utilizing outpatient (OPD) services	47	45	58	62	69	61	60	58	58	51	53
Average length of stay	1.14	1.79	1.49	3.3	1.1	3.4	2.13	0	1.2	1.1	1.2

Source: HMIS/DoHS

Executive Summary

Introduction:
This is first annual report of Health directorate, Ministry of Social Development Province no 2 for the fiscal year 2075/076. This report highlights the comparative analysis of few important health indicators and curative services indicators in addition, the report identifies, the issues /problems raised, and recommendation made by the stakeholders during provincial annual health review of the province. In province no 2, health services have been delivered to the people of the province through various level of health institutions. The province has one provincial level Hospital formerly recognized as Zonal Hospital 7 District Hospitals, 2 zonal Ayurveda Aushadhalaya, 8 district level Ayurveda Ausdhalaya 1045 Health Center 28 UHC 3384 EPI 2358 ORC 7622 FCHVs.

Child Health and Immunization
National Immunization Program (NIP) of Nepal (Expanded Program on Immunization) was started in 2034 BS and is a priority 1 program. It is one of the successful public health programs of Ministry of Health and Population and has achieved several milestones contributing to reduction in child morbidity and mortality associated with vaccine preventable diseases.

BCG coverage has increased by 3% point in FY2074/75 than 2073/74. The coverage of DTP- HepB-Hib 3 and OPV 3 has increased by 18% and 8 % points respectively compared to previous year. IPV global shortage started from FY 2073/74. So, FIPV was introduced from FY 2075/76 the coverage of fIPV I is 71% while fIPV II is only. The coverage of all antigens has improved compared to previous year. MR2 coverage has increased by 13% points compared to previous year. For measles elimination, high coverages of both MR 1 and 2 is required (≥ 95%). Therefore, coverages of MR 2 is still not satisfactory.

Integrated Management of Neonatal and Childhood Illnesses
IMNCI is an integration of CB-IMCI and CB-NCP Programs as per the decision of MoHP on 2071/6/28 (October 14, 2014). This integrated package of child-survival intervention addresses the major problems of sick newborn such as birth asphyxia, bacterial infection, jaundice, hypothermia, low birth-weight, counselling of breastfeeding. It also maintains its aim to address major childhood illnesses like Pneumonia, diarrhoea, Malaria, Measles and Malnutrition among under 5 year's children in a holistic way.

The Facility-Based Integrated Management of Neonatal and Childhood Illnesses (FB-IMNCI) package has been designed specially to address childhood cases referred from peripheral level health institutions to higher institutions. FBIMNCI package is linked strongly with the ongoing Community Based Integrated Management of Neonatal and Childhood Illness (CB-IMNCI).

In FY 2075/76, a total of 1,783 newborns cases were registered and treated at health facilities and PHC/ORC level which is less than that of previous year by 2,128 in total. Rautahat (441) had highest number of registered cases followed by Mahottari (379) and least case load was in Siraha (91). Out of total registered cases in FY 2075/76, 99 cases were classified as Possible Severe Bacterial Infection (PSBI) which accounts for 5.6 percent at provincial level which is slightly less than that of previous year (3.7%).

The proportion of PSBI was highest in Rautahat (39%) followed by Parsa (21%). Among the total registered cases at the provincial level (Health facilities and PHC-ORC level), 66.4 percent cases were classified as LBI and 0.8 percent as Jaundice. The proportion of LBI has increased while that of Jaundice decreases compared to last year. Among the total registered cases the proportion of LBI was highest in Mahottari (86%) followed by Rautahat (78%). Out of all cases identified percent cases 8% were referred and only Rautahat district reported newborn deaths. Total 6,923 cases were identified by

FCHVs as sick children out of which only Rautahat was responsible to report 20 percent reported in in FY 75/76.

Nutrition,

The National Nutrition Programme is priority programme of the government. It aims to achieve the nutrition well-being of all people so that they can maintain a healthy life and contribute to the country's socioeconomic development. There is a high-level commitment to improve the nutritional status especially of Adolescence, Pregnant and Lactating mother, and children under-five.

In FY 2074/75, the percentage of new-born with low birth weight (<2.5 kg) was11.9 %. About 70 % of children between 0-23-month-old were registered for growth monitoring with an average of 3 visits per child, among them 4.3% of were reported as underweight. During growth monitoring, 29.6 % children were exclusively breastfed, 6-8 months who received complementary foods .8%.

A total 26984 children of 6 months to 5 years with SAM admitted in outpatient therapeutic centres of 55 districts. Among discharged SAM cases, 75.7 percent were recovered, less than 1 percent died and 14.4 percent were defaulter. Similarly, total 2250 children were provided with nutritional care through 3 NRH.

In context of micronutrient supplementation, the coverage of first-time iron distribution to PLW is high as 73 percent but the compliance of taking 180 tablets throughout the pregnancy is 45% -and 45-days post-partum is 38 %. Average 45.6 percent of children aged 6 to 23 months had taken their first dose of MNP in the 41 programme districts. Compared to the 1st cycle of MNP intake, the 3rd cycle of intake indicating the compliance is drastically low at 15.6 percent. Households using adequately iodized is 95 percent. Vitamin A supplementation coverage is around 80% and deworming tablet distribution coverage is 78.8%. Likewise, coverage of school deworming is 38.4 percent for girls and 34.1 percent for boys.

In 2074/ for the floods, Nutrition cluster reached 1,400,772 children of 6-59 months and 160,950 pregnant and lactating women in 18 flood affected districts. Vitamin A supplemented (1,400,772), counselling on breast feeding and complementary feeding to the caretakers of 0-23 months children (297,281), screening of children (630,976), treatment of SAM (15,201), deworming of 12-59 months children (1,209,568), iron and folic acid tablets to PLW (160,950). Similarly, 190,379 children aged 6-59 months and 52,902 PLW reached with blanket supplementary feeding; and 23,392 children aged 6-59 months with MAM and 6,617 women with acute malnutrition reached with Targeted supplementary feeding programme.

Safe motherhood and Newborn health

During FY 2075/76, the province level ANC 4th visit (as per protocol) as percentage of expected pregnancy has been increased to 41 % as compare to 34 % in FY 074/75. Similarly, the institutional delivery has been increased to 53% in FY 075/76 as compare to 34% in FY074/75. The percentage of mothers who received three post-natal care visit as per protocol at HF among expected live birth has also slightly increase to 15 %in FY 075/76 from 14% of FY 074/75. During FY 075/76 a total of 9341 CAC service has been provided. Compared to fiscal year 2074/75, the proportion of women who had a safe abortion and then used contraceptives increased over the last year, from 79 percent in 2074/75 to 85 percent in 2075/76. The acceptance of post abortion contraception among medical abortion service users was high compared to among surgical abortion users. Overall, post-abortion LARC use is remained at 20% for the last two fiscal years.

Family Planning and Reproductive Health

At province level contraceptive prevalence rate for modern contraceptives (mCPR) increased to 49% in fiscal year 2075/76 from 47% in fiscal year 2074/75. The highest increase in mCPR was observed in Sarlahi district in 2075/76 as compared to last fiscal year while mCPR remained constant for the last three consecutive fiscal years in Parsa district at 71%. At province level among the total current users for all modern methods, number of female sterilization (459943 out of 589667 total current users) remained highest in absolute numbers. Similarly, among the temporary methods, number of depo users were the highest (46873), followed by implant users (21599) in the fiscal year 2075/76. The trends of users for long acting reversible contraceptive (LARCs) is increasing and the highest increase was observed for implants among the new users.

Depo (45%) occupies the greatest part of the contraceptive method mix for all method new acceptors, followed by pills (24%), permanent methods (14%), implants (13%) and IUCD (4%) in fiscal year 2075/76. There has been increase in post-partum uptake of FP method within 48 hours of delivery for long acting reversible methods while decreased uptake of permanent method was observed in FY 2075/76 as compared to FY 2074/75. Among the total new acceptors having age below 20 years, depo is most used method (56%) followed by pills (35%), implant (7%) and IUCD (2%).

Malaria

Annual blood slide examination rate has been varying throughout the last five years. There is slight increase in the ABSER from 0.2% to 0.5% in FY 075/076. Malaria Parasite Incidence has been gradually decreasing in comparison to the previous years. 0.0034% is observed in FY 075/076 which was 0.01% in 074/075. Likewise, slide positivity has also decreased. 60 Malaria cases were reported in the province in FY 075/076 of which 7 were diagnosed from Microscopy, 32 from RDT and 21 from both microscopy and RDT.

Kala-azar

6 kala-azar cases were reported in the province through EWARS. The last 2 years in the province which shows effective control measures being adopted to reduce kala-azar from the province no 2.

Dengue

13 confirmed dengue cases were reported in through different sites in the province 2, highest cases were reported in Saptari district which was 10 cases. Siraha, Dhanusha and Parsa reported one dengue cases each.

Lymphatic filariasis

209 lymphatic filariasis cases were reported int the province through HMIS. For the control of lymphatic filariasis, provincial level planning meeting was done. Health workers of Bara were oriented on MDA, drugs were supplied from central medical store to respective palika for treatment of LF cases.

Tuberculosis

All districts have been covered with DOTS. of DOTS from 828 treatment centers, sputum examination from 73 microscopy centers and 10 GeneXpert centers in province 2.

There are 828 treatment centers 73 microscopic centers, 3 DR centers, one MDR hostel and 10 gene xpert centers for the treatment and diagnosis of TB in province 2. The case notification rate at provincial level was 114 per 1 lakh population in this year 075/76. A total of 6836 TB cases were diagnosed in FY 075/076 which is an increase of 250 cases in absolute number. Sputum conversion rate in the province was recorded to be 89% while treatment success rate in the fiscal year was reported to be 90%. This is in line with the national target. A total of 62 DR TB cases were recorded for treatment in the fiscal year and treatment success rate of DR TB cases was below the national target of 70%.

Leprosy

Nepal declared leprosy as eliminated disease from Nepal. However, challenges have not ended from the province. New case detection rate has been gradually increasing as compared to previous year and prevalence rate has also increased as compared to previous year. Though prevalence rate is 2.4/10000 population. Disability grade II has been slightly decreased as compared to last fiscal year.

HIV/AIDS

Over the years HIV has been stabilized as a concentrated epidemic in the province, which is characterized by more than 5% HIV infection rates for certain Key population at higher risk (e.g. PWID) and less than 1% HIV prevalence rate in general population. There are a total of 8 HTC (HIV Testing & Counseling) centers in the province providing counseling and testing services to the both general and most at risk populations. ART services for those in need are provided through a total of 7 ART centers in the region. All the health facilities in the province can provide PMTCT services but because of irregular supply of HIV test kits the services are interrupted from time to time. In the fiscal year a total of 367 HIV cases were detected through testing of 42042 risk population in the province.

INTRODUCTION

1.1 Provincial Information

Province No. 2 is one of the seven provinces of Nepal established by the country's new constitution of 20 September 2015. It is situated in the central Terai which lies in the southern part of Nepal. It is the smallest province with area of 9661 KM^2 and population of about five and half million. It has highest population density (560/Km2) in the country. The province is covered by the Saptari-Koshi river in the east, Chitwan National Park in west, Province No.3 in north and the state of Bihar in India in South. The provisional headquarter for the Province No.2 is Janakpurdham, which is the center for religious and cultural activities. The Mithila region lying in between the Koshi and Gandaki rivers in the Terai is well known for its rich civilization. The temples, ponds, unique festivals, Mithila paintings and other beautiful scenes in the region are attractive. Under its jurisdiction, there are altogether 58 Rural Municipalities, 74 Municipalities, 3 Sub-Metropolitan Cities, and 1 Metropolitan City.

The province is composed of flat plains of Terai, Bhabar and Chure that lies on the northern side, and the southern side has an international border with India. It has eight verticals of districts from east to west namely Saptari, Siraha, Dhanusha, Mahottari, Sarlahi, Rauthat, Bara and Parsa. Here SaptaKoshi, Bagmati, Kamala, Lakhandai, Balan,Bakaiya and Ratu are the main rivers. It also boasts the country's largest industrial estate and customs point Birgunj, that generates the highest customs revenue for the fiscal coffers of the country. Also, Province No.2 is a leading producer of agro-products and a key source for food commodities. The province is very agro-based as majority of people are reported to be engaged in farming.

Eradicating poverty is an ardent challenge for the province. Furthermore, in the absence of economic momentum, no new jobs have been created outside subsistence sectors. This has eventually driven high number of young population (a demographic dividend) out of the country, and adversely affected the labor dependent economy. The agriculture sector is experiencing the shortage of labor and sharp increase in wages. Additionally, due to deforestation on Chure and Bhabar, silting of river is increasing and the rate of recharge of water is diminishing. This ecological depletion has resulted in low storage of ground water in all districts of this province.

1.2 Background

Health as fundamental right of all citizen, grantees the constitution of Nepal. Article 35 of this constitution further elaborates provision of free health care, information on health care, equal access to health care and access to clean drinking water and sanitation. Guided by the National Health Policy 2071 and Nepal Health Sector Strategy 2015-2020 (NHSS), different health programs were planned and implemented in the fiscal year 2075-76. The report is the output of the provincial health review conducted by Ministry of Social Development (MoSD) and Health Directorate.
This is the first provincial annual health report of its kind after the implementation of federal structure in Nepal. This report analyses the performance and achievements of province 5 in fiscal year 2074/75 (2017/2018). It focuses on performance in 2075/76 and the following areas that provide the basis improving performance in subsequent years:

- Programme’s policy statements, including goals, objectives, strategies, major activities and achievements
- Programme’s indicators
- Activities carried by various health entities under the MoSD
- Problems, issues, constraints and recommendations on improving performance and achieving targets.

This report also provides information on the contributions of the Department of Ayurveda, External Development Partners and stakeholders on contemporary issues in the health sector as well as the

progress of major programs implemented by MOHP, Ministry of Social Development, district health offices and hospitals within the province and health facilities.

All the data used in the report are obtained from District Health Information System- II (DHIS-2). This also includes data directly reported to different centres like NCASC and NTCC. The report also uses information from other Management Information Systems (MISs), disease surveillance systems. The main health sector MISs include the DHIS, the Logistics Management Information System (LMIS), the Financial Management Information System (FMIS), and the Ayurveda Reporting System (ARS). Likewise, this report also incorporated the information collected and compiled from municipalities in the districts and from external development partners within the province.

This report has eight chapters. Chapter 1 covers the background of annual report preparation, the structure of DoHS, and sources of information used for preparing this annual health report. Chapters 2 to 5 cover DoHS's different health care related programmes; Chapter 6 presents the programmes of the Ayurveda and Alternative Medicine; chapter 7 provides the details of external development partners in health sector in the province; while chapter 8 covers the administrative, managerial and programmatic issues and recommendations raised in the annual review meeting.

The preparation of this report follows the eight-district level annual performance review workshop and two days provincial annual performance review and planning workshop held on 13-14 Mangsir 2076 in Janakpurdham. These workshops were attended by Social Development Minister, MOSD Province 2, Secretary of MOSD, Director Generals of Department of Health Services, Department of Ayurveda and Alternative Medicine and Department of Drug administration; senior personnel from Ministry of Health and Population, Health Directorates, Health Division, MOSD, district, provincial and central hospitals, private hospitals and by representatives of External Development Partners (EDPs); national and international non-governmental organizations (NGOs and INGOs).

Workshop participants reviewed the policy statements of each program and analysed data generated by the DHIS-II and from other sources on selected indicators. These data were interpreted during the presentations and discussions.

The objectives of Provincial Annual Performance Review Workshop were to:

- Review the program implemented in fiscal year 2075/76 and draw lessons learned
- Develop action plan to be implemented in coordination with Municipalities (Palika), Province and Federal Government in current fiscal year.

1.3 Service Outlets in the Province

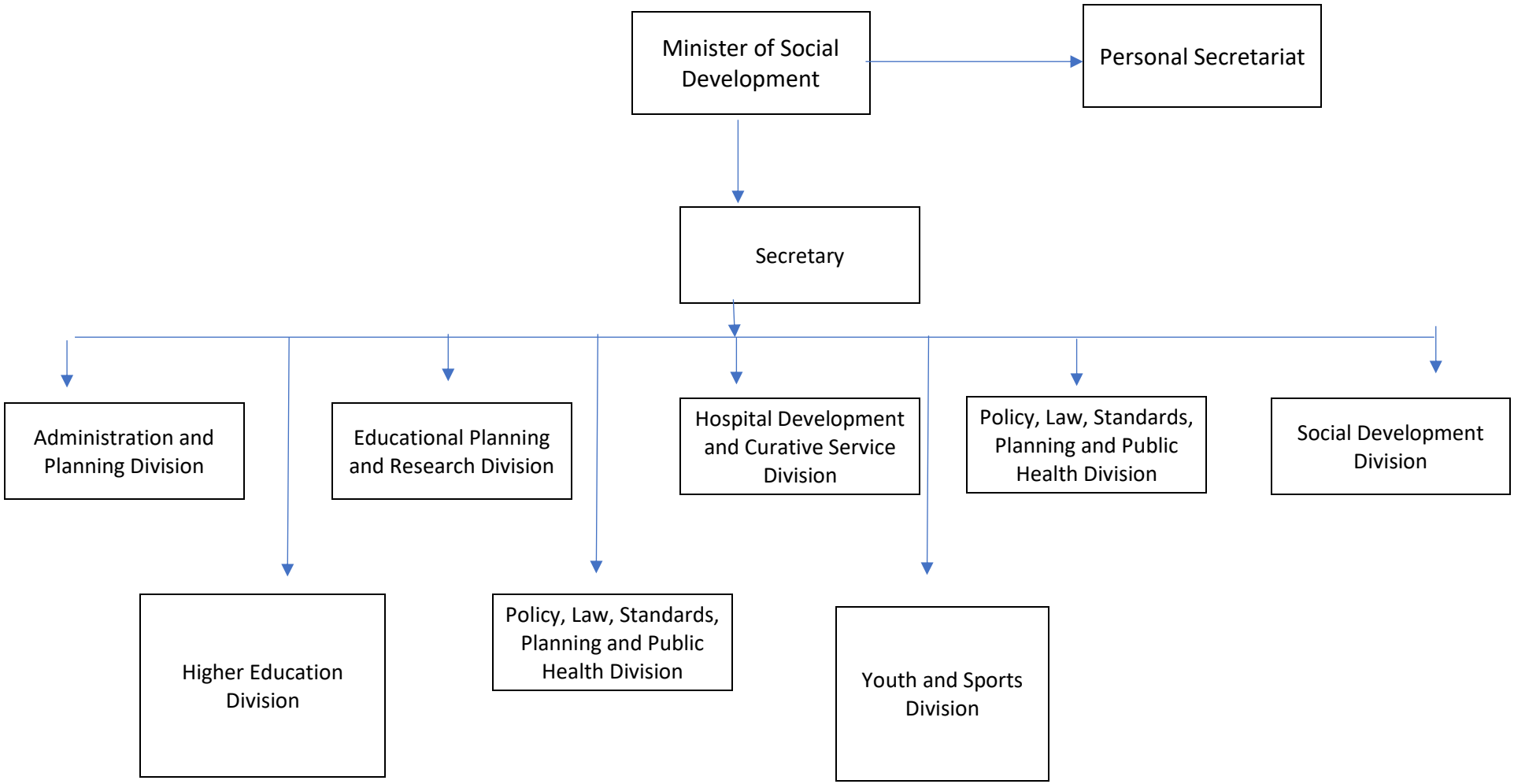
In the province there 13 government hospitals including district and provincial and central hospitals. Thirty-three primary health care centres and 748 health posts are also delivering the basic health care services to the communities in province 2. To increase the access and utilization of health care services, 28 urban heath centres, 10 community health units, 2358 PHCORCs and 3384 Immunization clinics are functional within the province. Similarly, 7622 FCHVs are being mobilized for public health promotion and prevention activities.

Table 1: Service outlets within the province

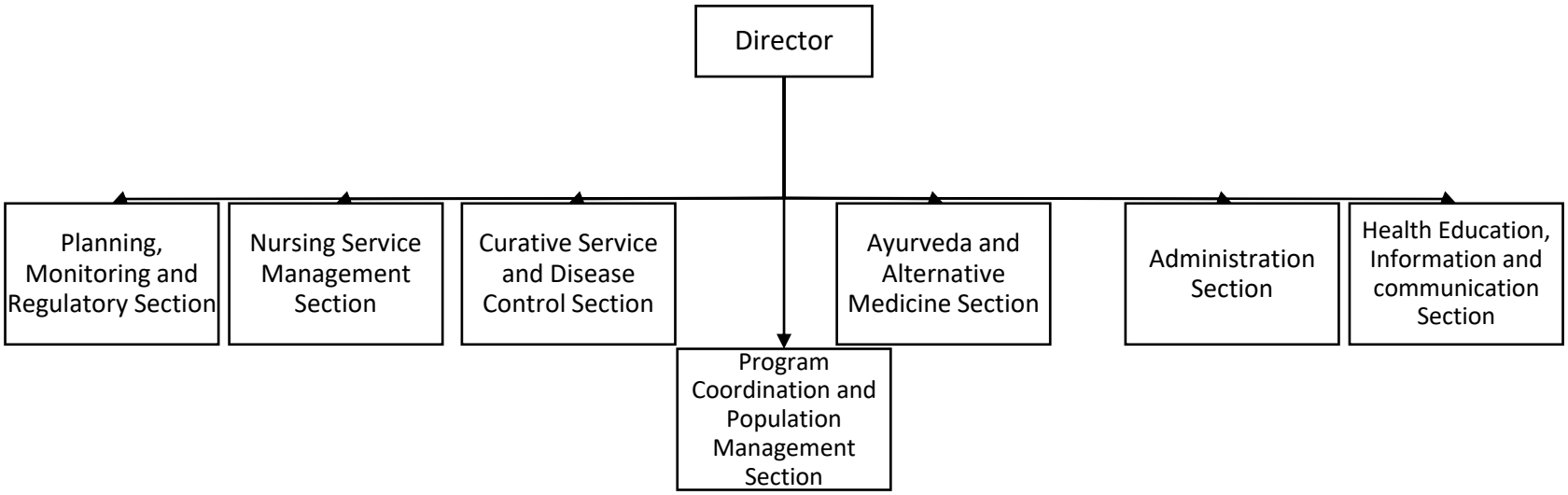
Service Outlets	Saptari	Siraha	Dhanusha	Mahottari	Sarlahi	Rautahat	Bara	Parsa	Province Total
Government Hospital	2	2	1	2	1	2	1	2	13

Primary Health Care Centre	4	4	5	4	5	3	5	3	33
Health Post	111	104	98	76	94	91	96	78	748
Urban Health Centre	2	2	4	4	0	0	12	4	28
Community Health Units	0	1	1	3	0	0	5	0	10
PHC-ORCs	406	251	322	273	226	333	277	270	2358
Immunization Clinics	460	432	486	359	344	422	493	388	3384
FCHVs	1016	1047	866	846	1299	909	1005	734	7622
Private Health facilities	8	62	37	13	15	10	30	38	213
Sentinel sites	1	2	2	1	1	1	1	2	11
No. of Outpatient Therapeutic Centres	26	19	21	16	20	19	19	17	157
Stabilization Centre for SAM cases	0	0	0	0	0	0	0	0	0
Nutrition Rehabilitation Home	1	0	1	0	0	0	0	1	3
Birthing Centre	24	23	14	13	25	22	13	22	156
DR Centre	0	0	1			1		1	3
Dr Sub Centre	2	3	4	2	2	2	1	1	17
Gene-Xpert	1	1	4	0	1	1	1	1	10
ART Sites	1	1	1	1	1	1	1	1	8
Ost Sites	0	0	0	0	0	0	0	1	1
DR Hostel	0	0	1	0	0	0	0	0	1

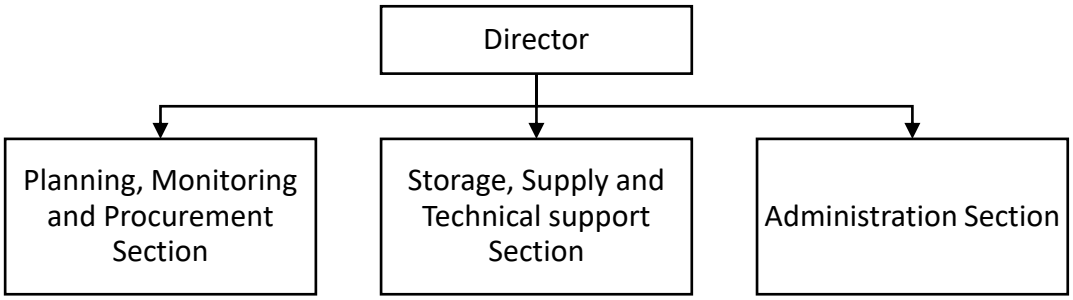
1.4 Organogram of Ministry of Social Development (MoSD), Province 2



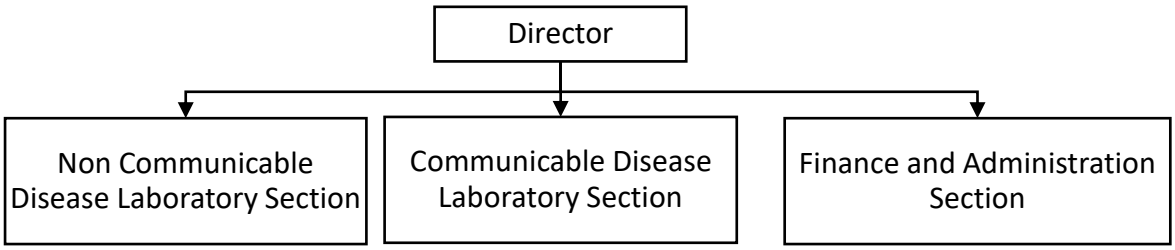
1.5 Organogram of Health Directorate, Province 2



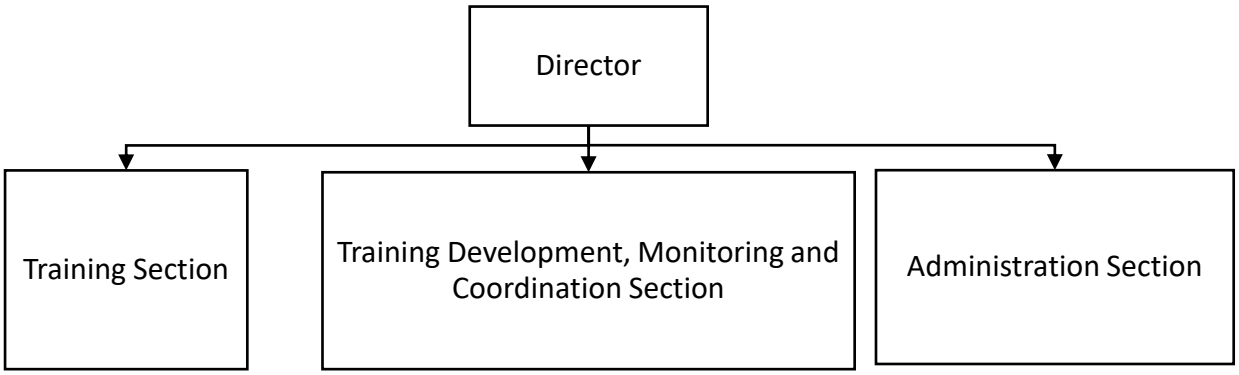
1.6 Organogram of Provincial Health Logistic Centre, Province 2



1.7 Organogram of Provincial Public Health Laboratory, Province 2



1.8 Organogram of Provincial Health Training Centre, Province 2



FAMILY WELFARE

2.1 National Immunization Program

2.1.1 Background

National Immunization Program (NIP) of Nepal (Expanded Program on Immunization) was started in 2034 BS and is a priority 1 program. It is one of the successful public health programs of Ministry of Health and Population and has achieved several milestones contributing to reduction in morbidity and mortality associated with vaccine preventable diseases.

NIP works closely with other divisions of Department of Health Services and national centres of Ministry of Health and Population, and different partners, including WHO and UNICEF, supporting the National Immunization Program. In the Decade of the Vaccines (2011 – 2020), NIP has introduced several new and underutilized vaccines contributing towards achievement of Global Vaccine Action Plan targets of introducing new and underutilized vaccines in routine immunization. Currently, the program provides vaccination against 11 vaccine preventable diseases. Recently, in August 2018, fractional dose of Inactivated Polio Vaccine was introduced in routine immunization of Nepal. As per comprehensive Multi-year Plan for Immunization (cMYP) 2017-2021, several other vaccines, including rotavirus vaccine, are planned for introduction in Nepal. Immunization services are delivered through 16,500 service delivery points in health facilities (fixed sessions), outreach sessions, and mobile clinics.

NIP has cMYP 2017 - 2021 aligned with global, regional and national guidelines, policies and recommendations to guide the program for five years. All activities outlined in the cMYP are costed and has strategies for implementation.

NIP has a very good track record of meeting the targets for control, elimination and eradication of vaccine preventable diseases. Small pox has now become history due to eradication in 2034 BS (1977 AD). Maternal and neonatal tetanus (MNT) was eliminated in 2005 and the elimination status has been sustained since then. The last case of polio in Nepal was in 2010, and alongwith other countries of the South East Asia Region, Nepal was certified polio free in 2014. This status has been maintained since then. Nepal is one of the first countries in the world to introduce JE vaccine in routine immunization. In 2016, JE vaccine, which initially was given only in 31 endemic districts, was scaled up all over the country, thus, further contributing towards control of Japanese encephalitis in Nepal. In August 2018, Nepal was certified as having achieved control of rubella and congenital rubella syndrome. This certification is two years ahead of the regional target year of 2020 and one year ahead of the national target of 2019. However, the national target of achieving measles elimination by 2019 will not be met. Measles, which is the most infectious disease, will require very high coverages (> 95%) with both the first and second doses of measles-rubella (MR) vaccine in every community, district, province, and nationally. Overall, the National Immunization Program is considered as the main contributor towards decline of infant and child mortality (Source: Nepal and the Millennium Development Goals, Final Status Report 2000- 2015, National Planning Commission), and has contributed significantly in achieving MDG Goal 4 of reducing child mortality.

Nepal is the first country in the South East Asia Region to have Immunization Act, thus supporting and strengthening the National Immunization Program. Immunization Act 2072 was published in the Official Gazette on 26 January 2016. Based on the Act, Nepal also has Immunization Regulation 2074, which was published in the Official Gazette on 6 August 2018. The Immunization Act of Nepal has recognized immunization as a right of all children. In line with this, one of the seven provinces of Nepal (Gandaki province) also has its provincial Immunization Act. Province No.2 has developed its own Provincial Immunization Act, which is in process of endorsement.

For supervision and guidance of the National Immunization Program, functional committees for both VPD surveillance and immunization exist in the country. The National Immunization Committee (NIC), National Immunization Advisory Committee (NIAC), and AEFI investigation committee are the committees mandated by the Immunization Act 2074, thus giving these committees status by legislation to guide the country immunization program.

Since FY 2069/70 (2012/13), Nepal has initiated and implemented a unique initiative known as 'full immunization program'. This program addresses issues of social inequity in immunization as every child regardless of social or geographical aspect within an administrative boundary are meant to be fully immunized under this program. Over the years, Nepal has witnessed participation of all stakeholders at all levels to achieve full immunization. Till date, Bara, Sarlahi, Siraha and Mahottari are declared as Fully Immunized Districts .

NIP produces evidences on burden of vaccine preventable diseases and impact of vaccine introduction. Nation-wide surveillance of acute flaccid paralysis (for polio), measles and rubella, neonatal tetanus, and Japanese encephalitis is conducted through WHO supported surveillance. Further, with support of WHO, sentinel surveillance of selected vaccine preventable diseases (invasive bacterial diseases, rotavirus, and congenital rubella syndrome) is conducted in collaboration with academia and research institutes.

NIP with the support of WHO works with various immunization and vaccine preventable diseases surveillance committees and task-forces which function as advisory and quality monitoring bodies of the program.

Guiding documents of National Immunization program

There are several global, regional and national guiding documents for the National Immunization Program. The main documents which have been taken in account and incorporated in cMYP 2017 - 21 are Global Vaccine Action Plan, South East Asia Regional Vaccine Action Plan, National Immunization Act 2072 and Nepal Health Sector Strategy (2016-2020).

Comprehensive Multi-Year Plan for Immunization (cMYP)

The comprehensive Multi-year Plan for Immunization (cMYP) 2012 - 16 ended in 2016 and new cMYP 2017-21 is in place. The cMYP 2017-2021 provides a plan for five years to achieve immunization related goals of the country. The objectives, strategies and activities set forth in the plan provide the framework required to meet the goal of reducing infant and child mortality and morbidity associated with vaccine-preventable diseases (VPDs). Furthermore, this plan addresses new challenges and expands the previous plan by providing guidelines for introduction of new vaccines, eradication, elimination and control of targeted VPDs and strengthening of routine immunization.

2.1.2 Vision

Nepal: a country free of vaccine-preventable diseases.

2.1.3 Mission

To provide every child and mother high-quality, safe and affordable vaccines and immunization services from the National Immunization Program in an equitable manner.

2.1.4 Goal

Reduction of morbidity, mortality and disability associated with vaccine preventable diseases.

2.1.5 Strategic Objectives

Objective 1 Reach every child for full immunization;

Objective 2 Accelerate, achieve and sustain vaccine preventable diseases control, elimination and eradication;

Objective 3 Strengthen immunization supply chain and vaccine management system for quality immunization services;

Objective 4 Ensure financial sustainability for immunization program;

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

2.1.6 National Immunization Schedule

Table 2: National Immunization Schedule

SN	Type of Vaccine	Number of Doses	Schedule
1	BCG	1	At birth or on first contact with health institution
2	OPV	3	6, 10, and 14 weeks of age
3	DPT-Hep B-Hib	3	6, 10, and 14 weeks of age
4	fIPV	2	6 and 14 weeks of age (applicable from FY 2075/76; previously given as IPV at 14 weeks)
5	PCV	3	6,10 weeks and 9 months of age
6	Measles-Rubella	2	First dose at 9 months and second dose at 15 months of age
7	JE	1	12 months of age
8	Td	2	Pregnant women: 2 doses of Td one month apart in first pregnancy, and 1 dose in each subsequent pregnancy
9	Rotavirus vaccine		planned for introduction in Nepal.

2.1.7 Major Activities Conducted in FY 2075/76

- Provincial level ToT and district level health worker and vaccinator training on Immunization training
- Training on Immunization program for the health workers of private/non-governmental health institutions and urban health clinics, and regional level training for new health workers on immunization and AEFI surveillance
- Immunization data verification, validation and monitoring for sustainability of municipality for Full Immunization Declaration program
- Sustainability of Full Immunization Declaration program by developing partnership in the municipalities having less vaccination coverage, difficulty in operating immunization services, and review of local resource mobilization
- Advocacy meeting about sustainable Immunization Programme with the members of the parliament, Policy makers, private sectors and civil society
- District level review of the hygiene promotion through immunization program
- Orientation training for municipality micro-planning
- Orientation/training to health facility in-charge, municipality CEO, and ward secretary to ensure full immunization and its sustainability
- Planning and orientation to FCHVs for identification of hard to reach and drop-out children for full immunization
- Draft prepared of Provincial Immunization Act, 2074
- Effective implementation of concurrent immunization supervision and monitoring mechanism through program staff, partners (UNICEF), SMO network, independent monitors, and immunization and VPD committee members at low performing areas
- Focused district activities for immunization intensification

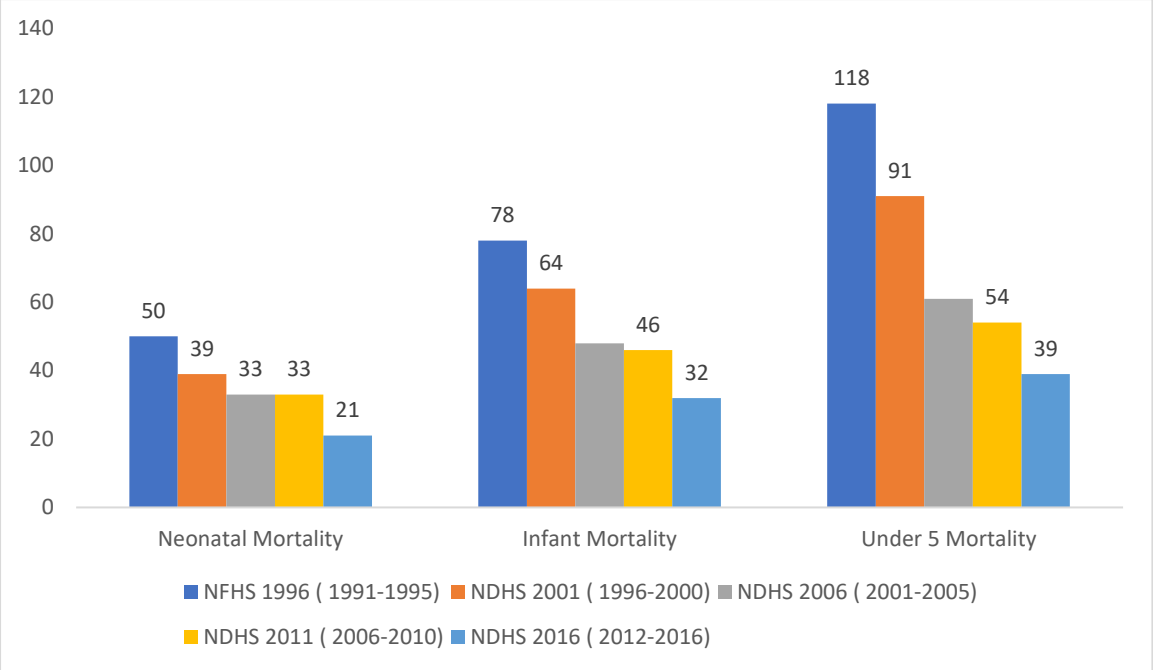
- Even when district health structure was temporarily dissolved due to structural changes in the federal system, with coordination from all levels, the supply of vaccine was maintained through the already existed system to assure proper maintenance of cold chain
- Conduction of Workshop to review and Immunization Act

2.1.8 Major Achievement

2.1.8.1 VACCINATION TARGET vs. ACHIEVEMENT, FY 2075/76

The cMYP 2017-21 has set the goals to reduce child mortality, morbidity and disability associated with vaccine preventable diseases, and one of the strategic objectives is to reach every child for full immunization. The NDHS survey 2016 shows that in 20 years, there has been significant reduction in infant and child mortality (Fig. 4.1.1). The National Immunization Program has contributed significantly in reduction of child mortality by preventing vaccine preventable diseases.

Figure 1: Trends in early childhood mortality



2.1.8.2 National vaccination coverage:

The table and maps presented below show the routine immunization vaccination coverages and achievement status in FY 2075/76.

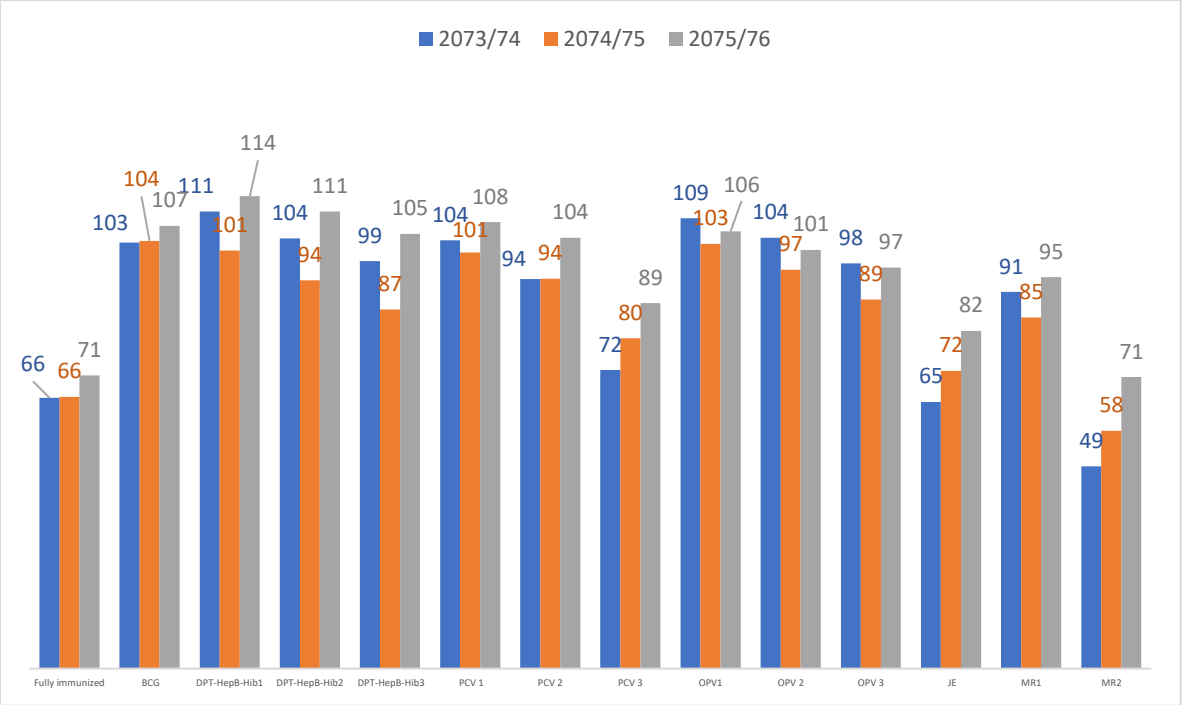
Table 3: Provincial vaccination coverage by vaccine, FY 2075/76

SN	Antigens	Target population	Targets	Achievement	% Achieved
1	BCG	under 1 Year	124422	133355	107.2
2	DPT-Hep B-Hib 1	under 1 year	124422	142327	114.4
3	DPT-Hep B-Hib 2	under 1 year	124422	137760	110.7
4	DPT-Hep B-Hib 3	under 1 year	124422	131067	105.3
5	DPT-Hep B-Hib 3 Including delayed dose given after 1 year of age	under 1 year	124422	137954	110.8
6	OPV 1	under 1 year	124422	131806	105.9
7	OPV 2	under 1 year	124422	126170	101.4
8	OPV 3	under 1 year	124422	120758	97.1

9	OPV 3 (Including delayed dose given after 1 year of age)	under 1 year	124422	127645	102.6
10	FIPV 1	Under 1 year	124422	88453	71.1
11	FIPV 2	Under 1 year	124422	51920	41.7
12	PCV1	under 1 year	124422	134486	108.1
13	PCV2	under 1 year	124422	129806	104.3
14	PCV3	under 1 year	124422	110120	88.5
15	Measles-rubella 1st dose	under 1 year	124422	117896	94.8
16	Measles-rubella 2nd dose	15 Months	128814	90956	70.6
17	JE	12 months	128814	105364	81.8
18	Td 2 andTd2 +	Pregnant women	151461	126345	83.4

Source: HMIS/MD, DoHS

Figure 2: Provincial Routine Immunization Administrative Coverage (%), Province no. 2, (FY 2073/74 to 2075/76)



Source: HMIS/MD, DoHS

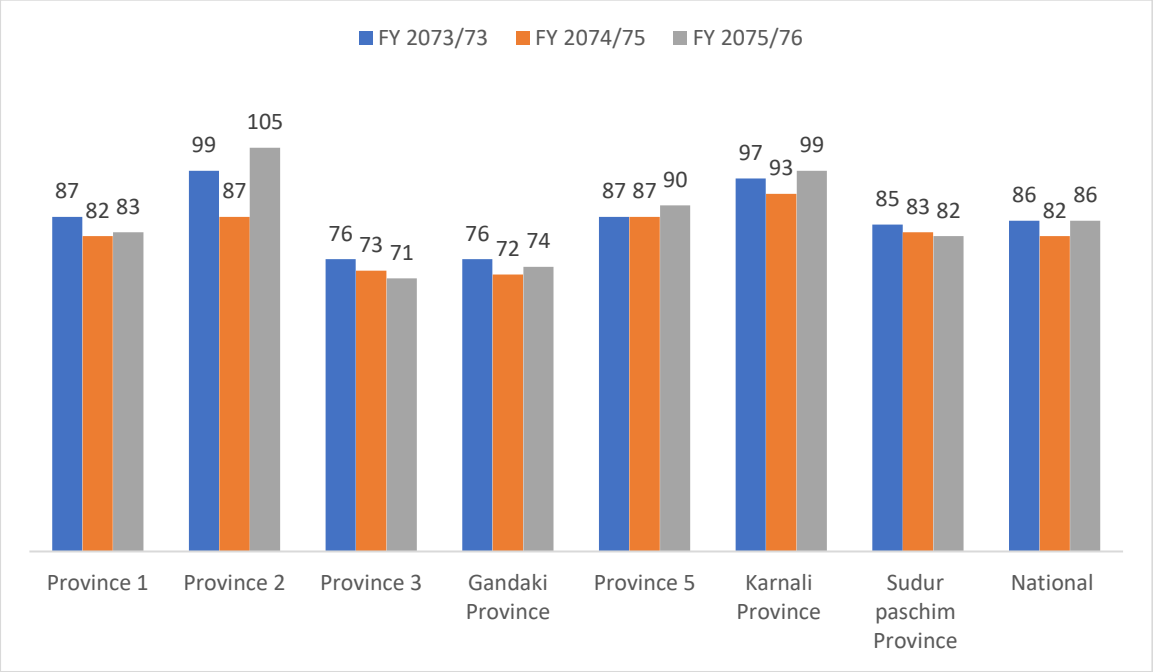
*DPT-HepB-Hib 3 coverage including delayed doses given after 1 year of age is:
FY 2073/74: 106.6 %
FY 2074/75: 95.2%
FY 2075/76 :110.8 %
** OPV3 coverage including delayed doses given after 1 year of age is:
FY 2073/74: 106 %
FY 2074/75: 97.6%
FY 2075/76 : 102.5%

The Figure 2 shows vaccine wise provincial administrative coverage for three years, from FY 2073/74 to FY 2075/76. BCG coverage has increased by 3% point in FY 2074/75. However, the coverage of DTP-HepB-Hib 3 and OPV 3 has increased by 18% and 8 % points respectively compared to previous year. IPV global shortage started from FY 2073/74. Therefore, FIPV was introduced from FY 2075/76 the coverage of FIPV I is 71% while FIPV II is only 42%. The coverage of all antigens has improved

compared to previous year. MR2 coverage has increased by 13% points compared to previous year. For measles elimination, high coverages of both MR 1 and 2 is required (≥ 95%). Therefore, coverages of MR 2 is still not satisfactory.

Vaccination coverages by province:

Figure 3: Province wise coverage of children under one year immunized with DPT-HepB-Hib3, FY 2073/74 to FY 2075/76



Source: HMIS/MD, DoHS

Figure 4: Province wise coverage (%) of measles-rubella first dose, FY 2073/74 to FY 2074/76

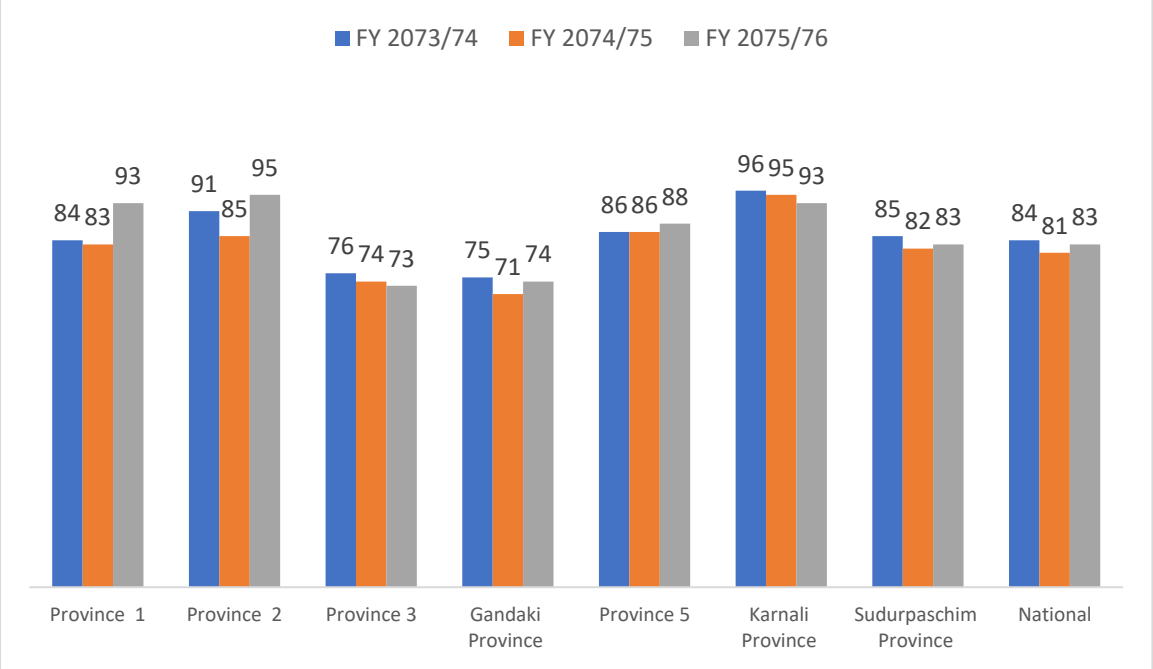


Figure 5: Province wise measles-rubella second dose , FY 2073/74 to FY 2075/76

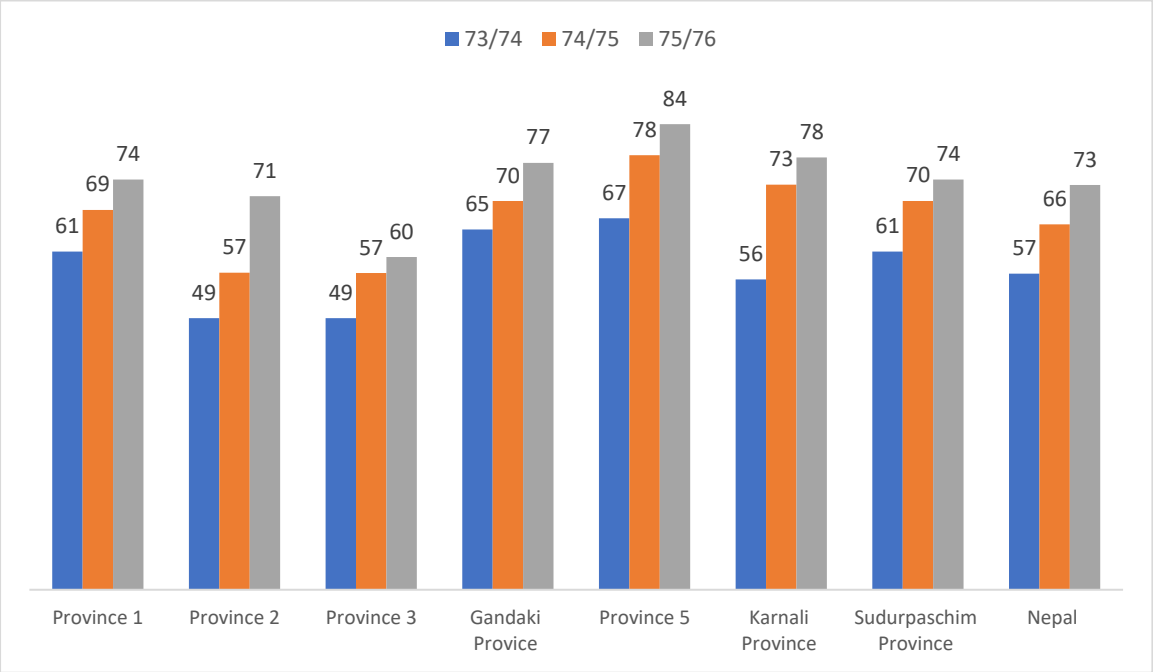


Figure 3 to 5 shows province wise coverage for DPT-HepB-Hib 3, MR 1, MR2, and Td 2/Td 2+ respectively. For DPT-HepB-Hib 3 and MR1, Province no. 2, Province no. 5 and Karnali Province has reported highest administrative coverages whereas Province 3 and Gandaki Provinces have reported relatively lower coverages. For MR 1, Province no.1 , Province no.2 and Karnali has reported the highest coverage in FY 2075/76 ; whereas, for MR2, Province 5 has reported the highest coverage.

4.1.1.1 Vaccination coverages by district :

Figure 6: District wise coverage of Percentage of children under one year immunized with DPT-HepB-Hib3, (FY 2073/74 to FY 2075/76)

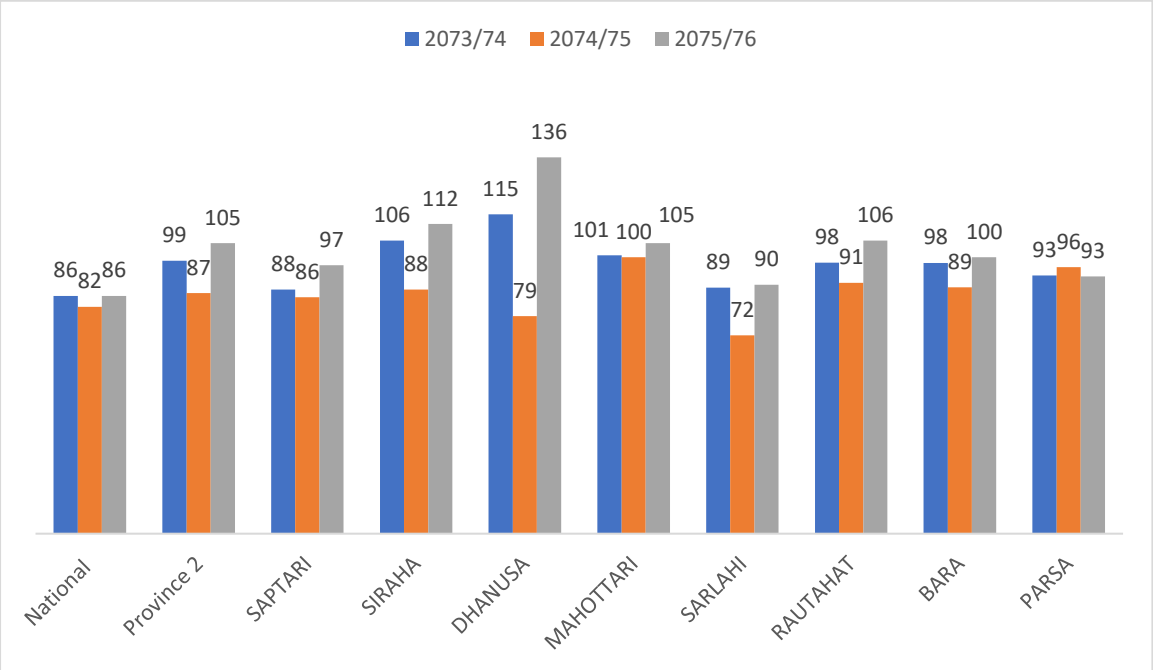


Figure 7: Percentage of children under one year immunized with Measles-rubella first dose

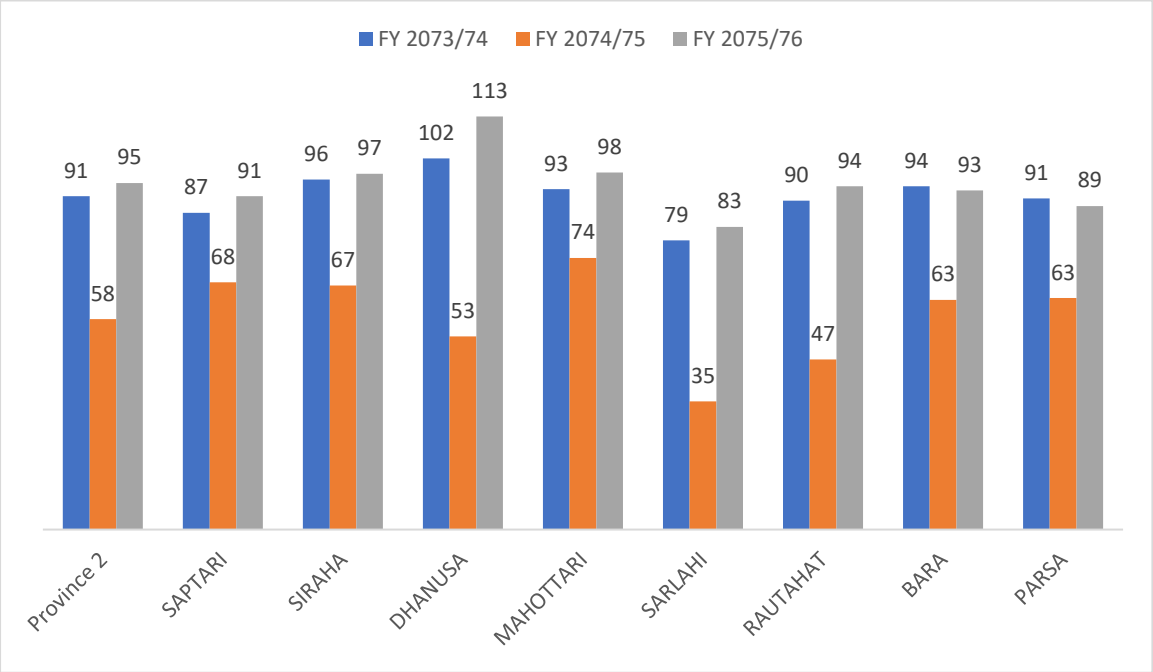


Figure 8: District-wise coverage (%) of measles-rubella second dose, FY 2073/74 to FY 2075/76

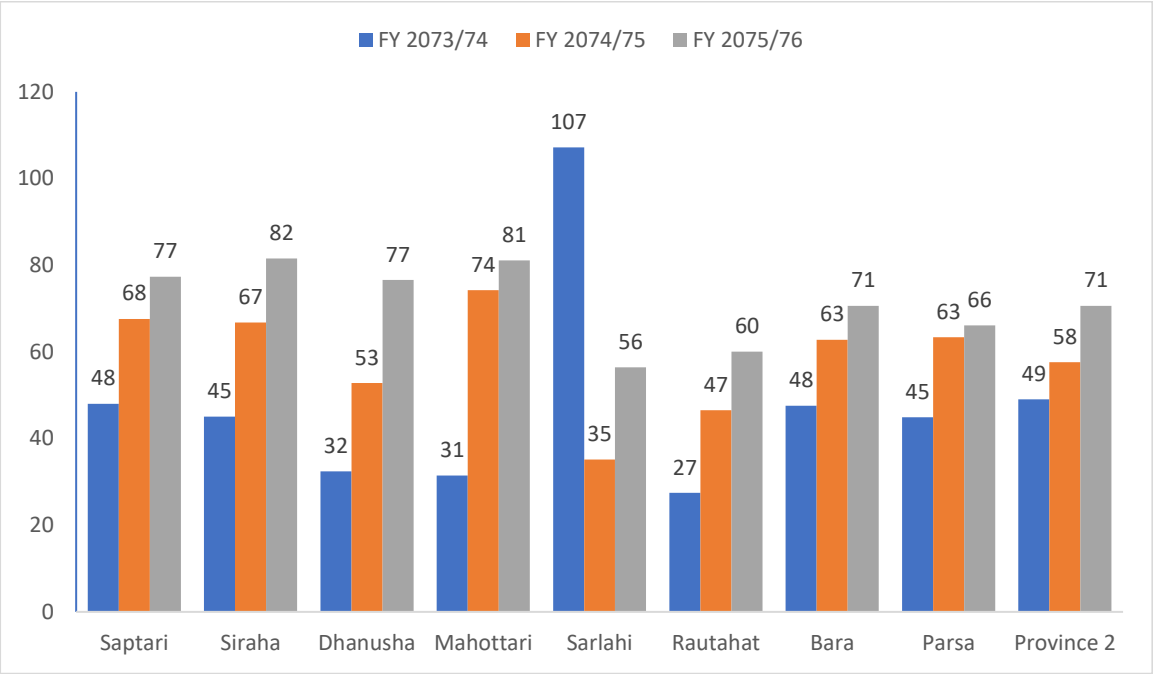
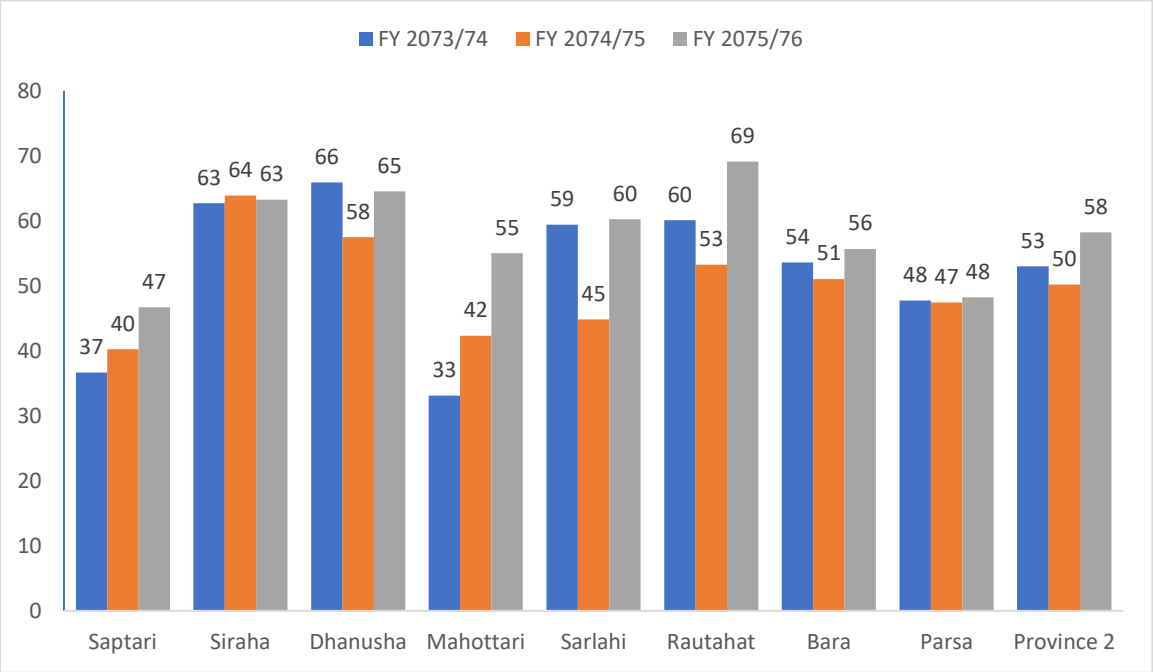


Figure 9: District-wise coverage(%) of TD 2+, FY 2073/74 to FY 2075/76

Source: HMIS/MD, DoHS



Source: HMIS/MD, DoHS

Figure 10: District wise coverage of pregnant women who received TD2 andTD2+

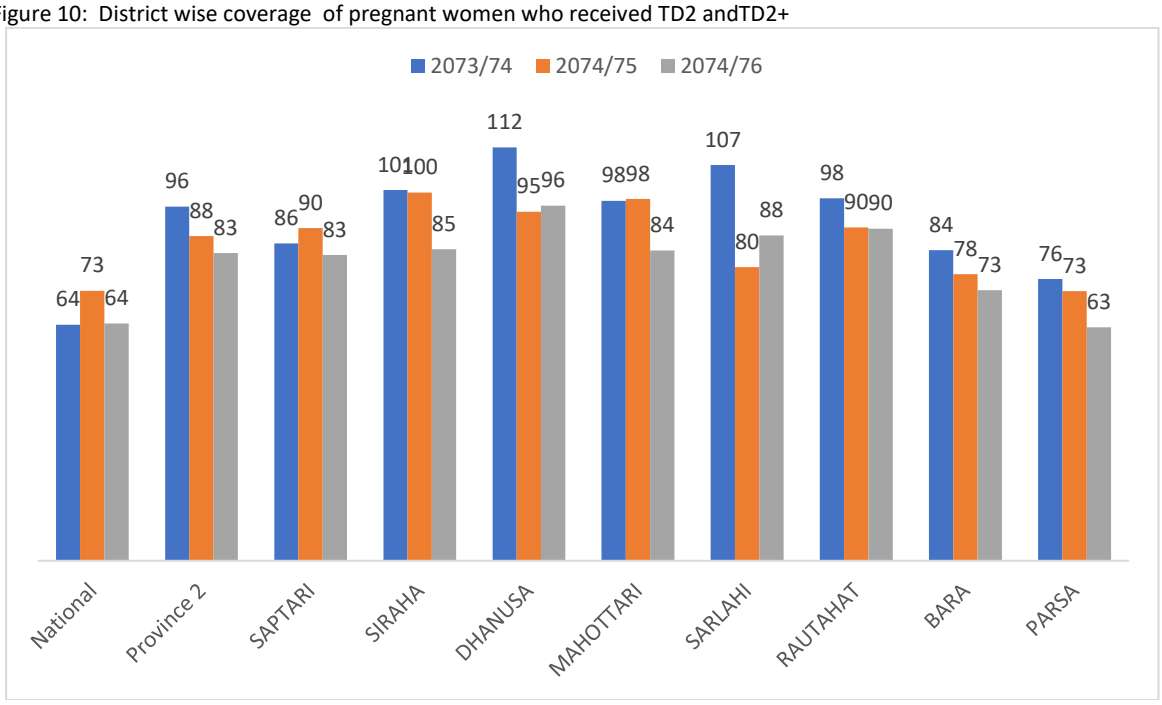


Figure 6 to 10 show district wise coverage for DPT-HepB-Hib 3, MR 1, MR2, and Td 2/Td 2+ respectively. For DPT-HepB-Hib 3 , MR 1 Dhanusha as reported highest administrative coverage whereas Sarlahi and Parsa have reported relatively lower coverage . For MR 2, Siraha and Mahottari has reported the highest coverage while Sarlahi has reported lowest coverage in FY 2075/76; whereas, for Td 2/Td 2+, Dhanusha has reported the highest coverage while Parsa has the lowest .

4.8.1.4. Dropout rates of vaccination: (national)

Figure 11: Dropout rates (%) of different vaccinations, FY 2073/74 to FY 2075/76 (national)

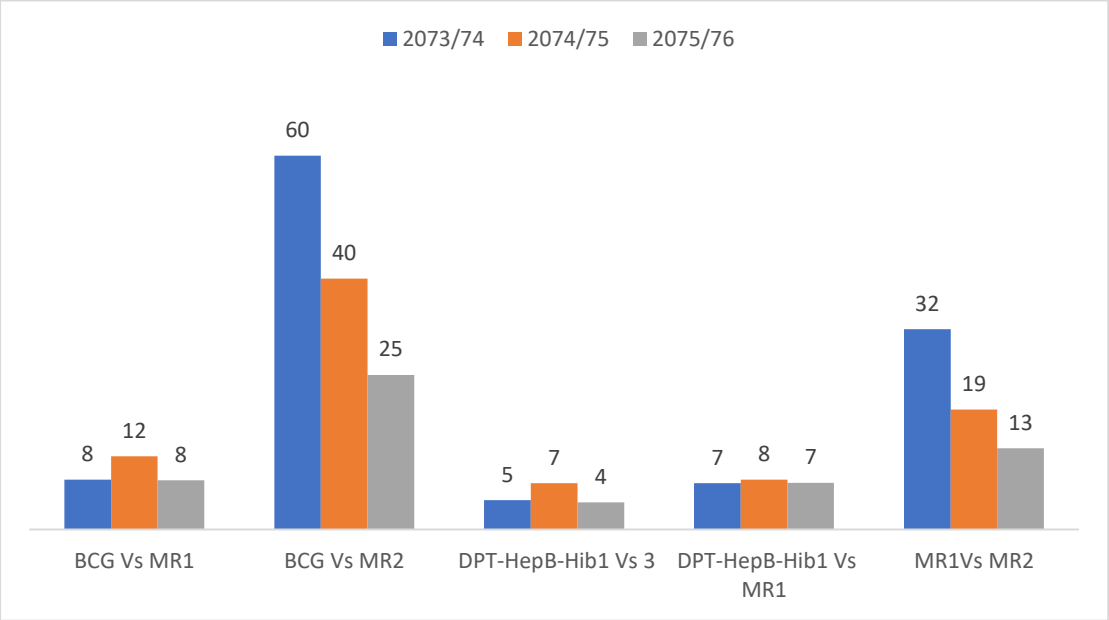
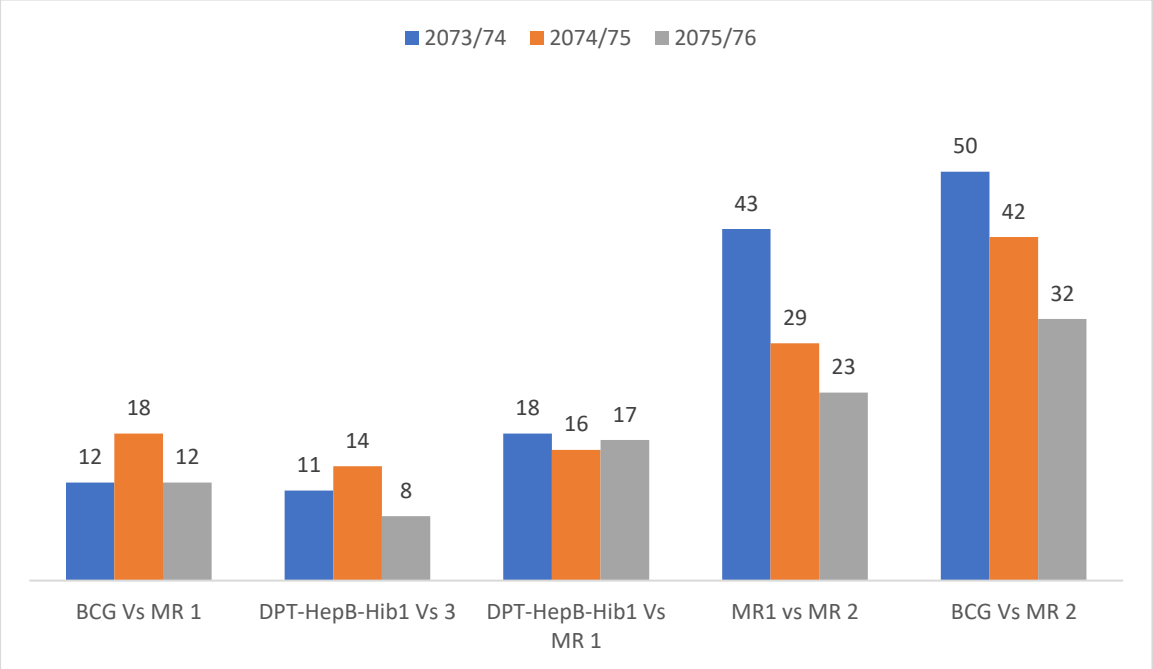


Figure 11 shows that national dropout rate for BCG Vs MR1, BCG Vs MR2, DPT-HepB-Hib 1 vs 3 and MR 1, and MR1 Vs MR2, although it has decreased compared to previous years, is within 10%. However, the dropout rate of BCG vs MR 2, and MR1 Vs MR2 is 25 % and 13% respectively in FY 2075/76.

Dropout rates of vaccination: (Provincial)

Figure 12: Provincial data drop out Dropout rates (%) of different vaccinations, FY 2073/74 to FY 2075/76



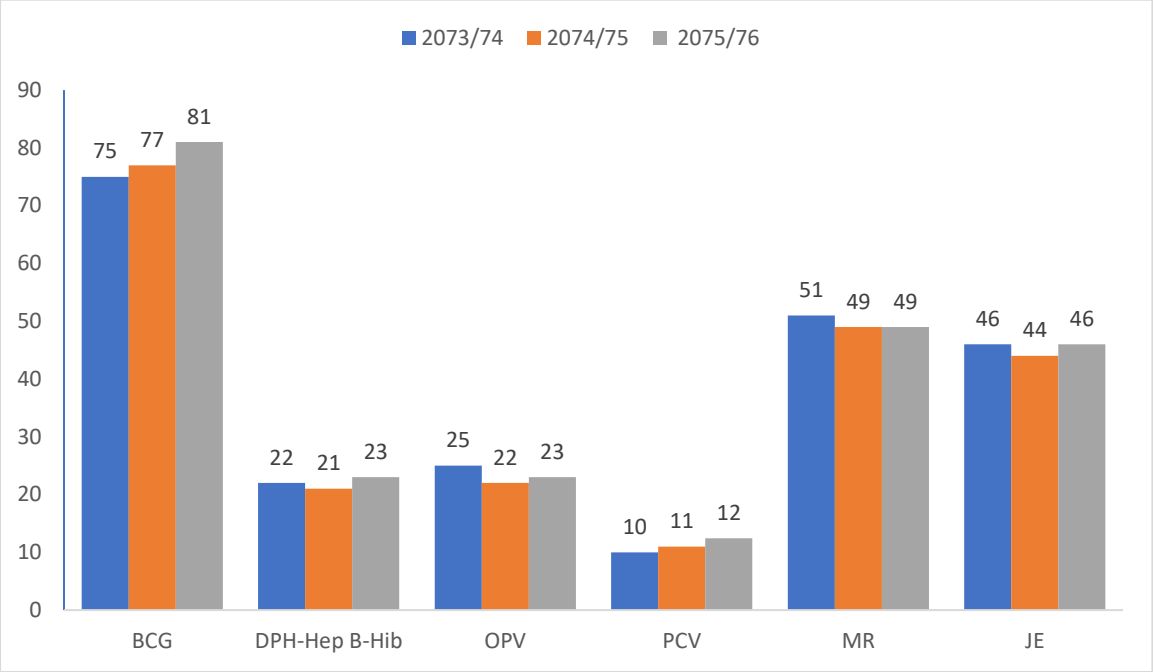
Source: HMIS/MD, DoHS

Figure 12 shows that provincial dropout rate for BCG Vs MR1, BCG Vs MR2, DPT-HepB-Hib 1 vs 3 , and MR1 Vs MR2 although it has decreased compared to previous years except DPT-HebB-Hib1 Vs MR1

which is slightly increased. Only DPT-HepB-Hib 1 vs 3 is within 10%. However, the dropout rate of BCG vs MR 2, DPT-HebB-Hib1 Vs MR1, and MR1 Vs MR2 is 32 %, 17% and 23% respectively in FY 2075/76.

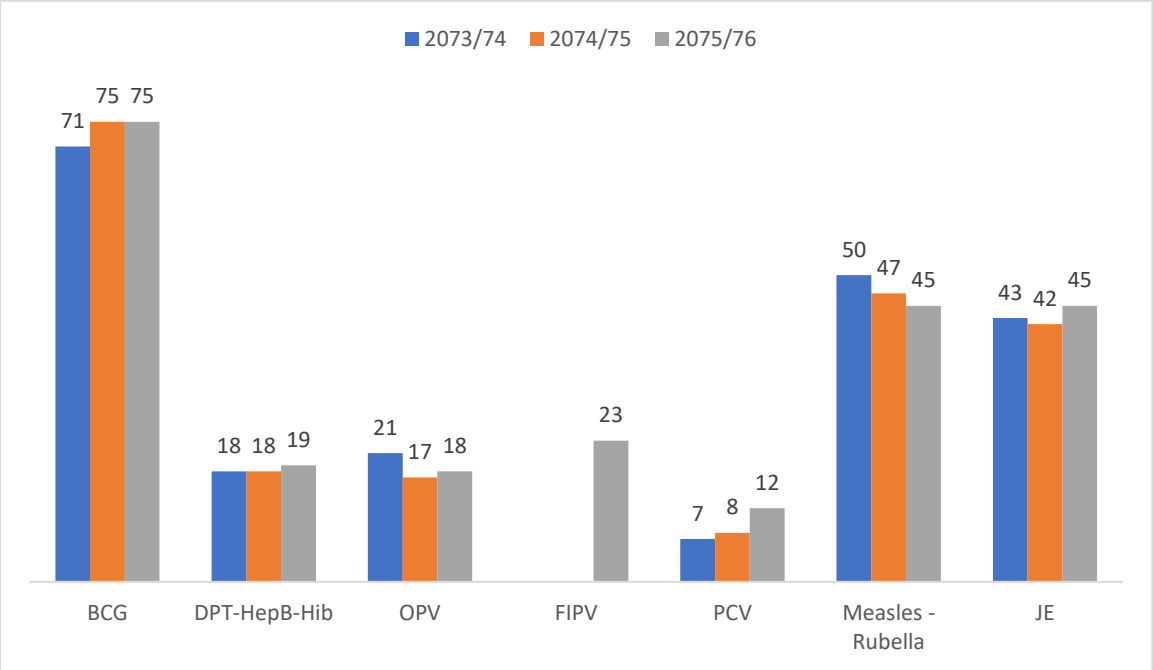
4.8.1.4. Vaccine wastage rates:

Figure 13: Vaccine wastage rates (%) Nepal, FY 2073/74 to FY 2075/76



Source: HMIS/MD, DoHS

Figure 14: Vaccine wastage rates (%) Province , FY 2073/74 to FY 2075/76

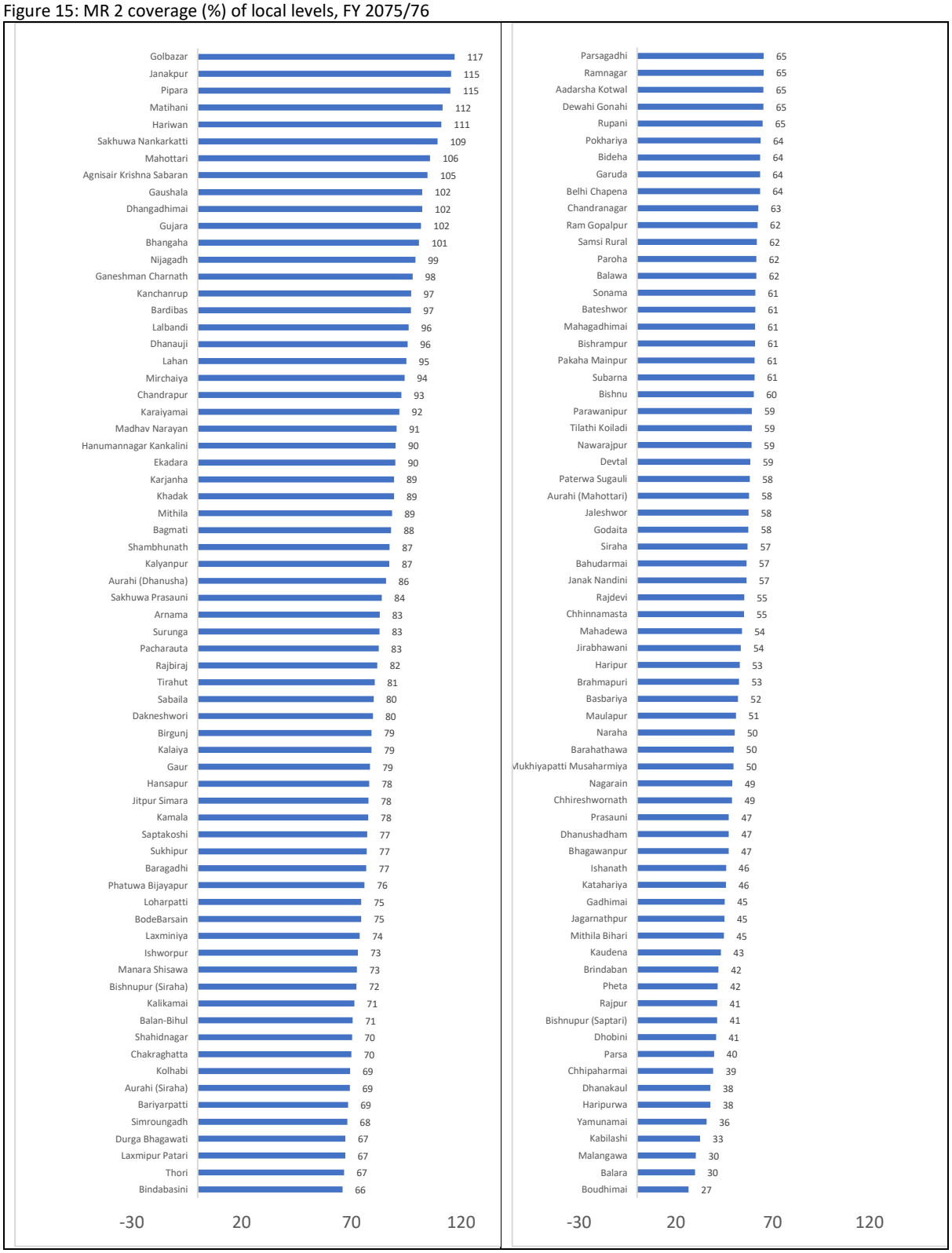


For all re-constituted vaccines (BCG, MR, and JE) that need to be discarded within 6 hours (1 hour only for JE) or at the end of immunization session whichever comes first, wastage rates are expected to be higher. Further, in Nepal, for BCG, MR and JE vaccines, at least 'one vial per session' policy is used,

consequently have allowed higher wastage rates. Because of these reasons, the wastage rates for BCG and JE are higher that the indicative wastage rates of 50% and 10% respectively.
However ,nationally and provincially, the wastage rate of antigens are slightly increased than previous year, while BCG remains stationary in Province no. 2.
But,, the wastage rate of MR has improved in Province no. 2 and is below the indicative wastage rate of 50%. For DPT-HepB-Hib and OPV, the provincial wastage rates are below the indicative wastage rate of 25% for both vaccines. For PCV vaccines, the provincial wastage rate is slightly higher than indicative wastage rate of 10%.

Measles-rubella second dose coverage by local levels:

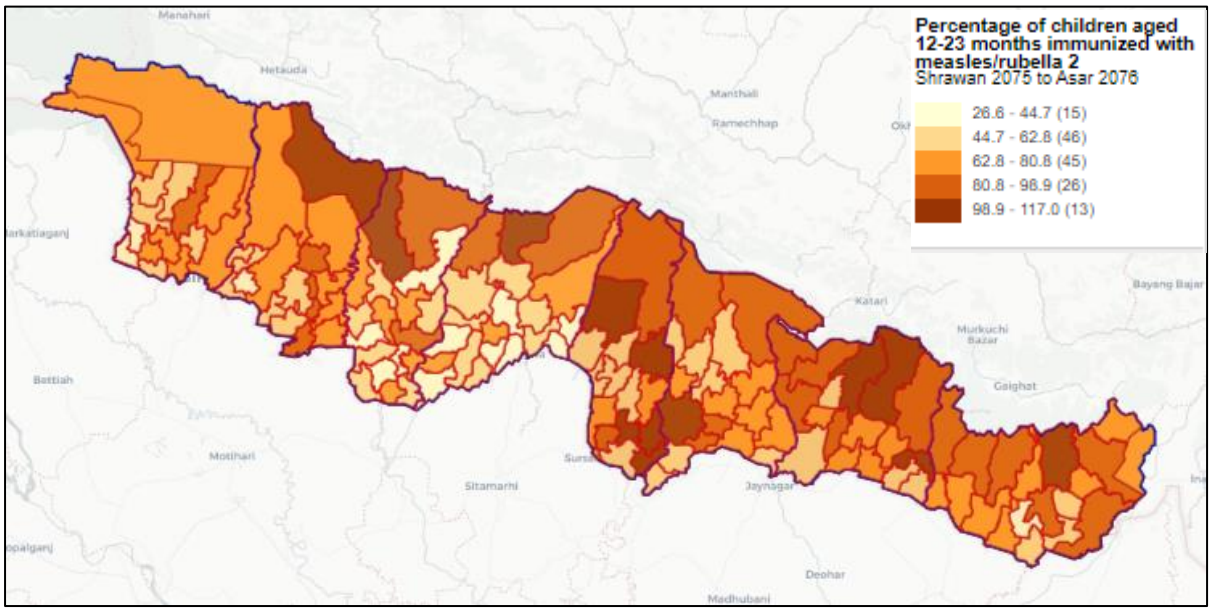
Figure 15: MR 2 coverage (%) of local levels, FY 2075/76



Source: HMIS/MD, DoHS

Figure 15 shows the coverage of MR 2 by Local ,25 local levels have achieved MR 2 coverage above or 90%, whereas 15 local levels have MR2 coverage between 80-89%, 71 local levels have MR2 coverage between 50- 79%, and 25 local have coverage below 50%. The national coverage of MR 2 is 71%. Figure 16 shows the coverage of MR 2 and number of unimmunized children for FY 2075/76.

Figure 16: Coverage and number of unimmunized for MR 2 by district, FY 2075/76



Source: HMIS/MD, DoHS

4.1.8.6 Access and utilization of immunization services:

National Immunization Program evaluates the status of the districts by accessibility and utilization of immunization services. Local levels are categorized in category 1 to 4 on the basis of DPT-HepB-Hib 1 coverage and dropout rate of DPT-HepB-Hib1 vs DPT-HepB-Hib 3 to know the accessibility and utilization of immunization services respectively.

Table 4: Local levels and districts categorization based on access (DPT-HepB-Hib1 coverage) and utilization (DPT-HepB-Hib 1 vs 3 dropout), FY 2075/76

Category 1 (less Problem) High Coverage (>90%) Low Drop-Out (<10%)	Category 2 (Problem) High Coverage (>90%) High Drop-out (>10%)	Category 3 (Problem) Low Coverage (<90%) Low Drop-out (<10%)	Category 4 (Problem) Low Coverage (<90%) High Drop-out (>10%)

Province no. 2, Saptari, Saptakoshi, Kanchanrup, Agnisair Krishna Sabaran, Rupani, Shambhunath, Khadak, Surunga, Balan-Bihul, BodeBarsain, Dakneshwori, Belhi Chapena, Bisnhupur, Mahadeva, Tirahut, Hanumannagar Kankalini, Siraha, Lahan, Dhangadhimai, Golbazar, Mirchaya, Karjanha, Kalyanpur, Naraha, Bishnupur, Arnaman, Sukhipur, Laxmipur Patari, Sakhuwa Nankarkatti, Nawarajpur, Bariyarpatti, Aurahi, Siraha Ganeshman Charnath, Dhanushadham, Mithila, Bateshwor, Chhireshwornath, Laxminiya, Hanspur, Sabaila, Shahidnagar, Kamala, Janak Nandini, Bideha, Aurahi, Dhanauji, Bardibas, Gaushala, Sonama, Bhangaha, Balawa, Ramgopalpur, Mahottari, Pipara, Maitihani, Lalbandi , Hariwon, Basbariya, Gurjara, Phatuwa Bijayapur, Madhavnarayan, Garuda, Dewahi, Maulapur, Paroha, Rajdevi, Bishrampur, Karaiyamai, Baragadhi, Aadarsha Kotwal, Pacharauta, Devtal, Subarna, Paterwa Sugauli, Sakhuwa Prasauni, Parsagadhi, Birgunj , Pokhariya, Kalikamai, Pakaha Manipur, Bindabasinin (81)	**Rajbiraj,** Chhinnamasta, Bhagwanpur, Mithila Bihari, **Janakpur,** Nagarain, Mukhiyapatti Musaharmiya, **Aurahai (Mahottari), Loharpatti,** Samsi, Manara Shisawa, EKdara, Bagmati, Barathathawa, Haripur, Ishworpur, Parsa, Brahmapur, Chandranagar, Kabilashi, Chakraghatta, Dhankaul, Ramnagara, Godaita, Bishnu, Kaudena, Katahariya, Brindaban, Gadhimai, Boudhimai, Rajpur, Yamunamai, Durgabhagwoti, Gaur, Ishanath , Nijgadh, Jitpur Simara, Parwainpur, Pheta, Simroungadh, Mahagadhimai, Jagarnathpur, Bahudarmai, Dhobani, Chhipaharmai, **(46)**	Tilathi Koiladi, Jaleshwor , Malangwa, Chandrapur, Kolhabi, Prasauni, Thori, (7)	**Balara, Jirabhawani, (2)**
District and Province			
Province no.2, Saptari, Siraha, Dhanusha, Mahottari, Bara, Parsa, (6)	Sarlahi, Rautahat, (2)		

Source: HMIS/MD, DoHS

Note: the given DPT-HepB-Hib 3 coverages used in the table above does not included delayed vaccines given after 1 year of age

Table 4 shows that 81 are in category 1 (good access, good utilization), 46 locals are in category 2 (good access, poor utilization), 7 locals are in category 3 (poor access, good utilization), and 2 local levels are in category 4 (poor access, poor utilization). Similarly, for districts, 6 districts are in category 1 while 2 districts are in category 2 and Province no. 2 falls on category 1.

2.2 Nutrition Programme

Background

Nutrition section under the Family Welfare Division is responsible for national nutrition program for improving the nutritional status of children, pregnant women and adolescents. Its goal is to achieve nutritional well-being of all people to maintain a healthy life to contribute in the socio-economic development of the country, through improved nutrition program implementation in collaboration with relevant sectors. Nutrition interventions are cost effective investments for attaining many of the Sustainable Development Goals. In alignment with international and national declarations and national health policies, the Government of Nepal is committed to ensuring that its citizens have adequate food, health and nutrition. The Constitution (2015) ensures the right to food, health and nutrition to all citizens. Hunger and under-nutrition often result in the vicious cycle of malnutrition and infections that leads to poor cognitive and intellectual development, less productivity and compromised socioeconomic development.
Focus on nutrition — Nutrition is a globally recognized development agenda. Since the year 2000, several global movements have advocated nutrition for development. The Scaling-Up-Nutrition (SUN) initiative calls for multi-sectoral action for improved nutrition during the first 1,000 days of life. The Government of Nepal as an early member of SUN, adopted the Multi-sector Nutrition Plan (MSNP) in 2012 to reduce chronic malnutrition. Recently, the UN General Assembly declared the 2016–2025 period as the Decade of Action on Nutrition.

Policy initiatives — The National Nutrition Policy and Strategy was officially endorsed in 2004 to address all forms of malnutrition including under-nutrition and over-nutrition. This policy provides the strategic and programmatic directions in the health sector while the MSNP provides a broader policy framework within and beyond the health sector under a Food and Nutrition Security Secretariat of the National Planning Commission that coordinates its implementation. The National Health Policy, 2076 highlights improved nutrition via the use and promotion of quality and nutritious foods generated locally to fight malnutrition. The Nutrition Technical Committee was established in then Child Health Division, now Family Welfare Division (FWD) in 2011 to support multi-sectoral coordination for developing nutrition programme.
Aligning with the MSNP and current global initiatives, FWD – nutrition section has developed strategies and plans for improving maternal infant and young child nutrition assisted by experts from the Nutrition Technical Committee. Moreover, as recommended by the Nepal Nutrition Assessment and Gap Analysis (NAGA) and guided by MSNP, in 2012–2013 MoHP conducted an Organization and Management Survey towards establishing a National Nutrition Centre for implementing MSNP in the health sector. Recently, MSNP -2 has been approved for 2075/76 – 2079/80 and being implemented in all districts except Siraha in province-2.

Malnutrition in Nepal
Despite a steady decline in recent years, child under-nutrition is still unacceptable in Nepal. Maternal malnutrition is also a problem with 17 percent of mothers suffering from chronic energy deficiency alongside the increasing trend of overweight mothers (22 %, NDHS, 2016). Although Nepal's effort in micronutrient supplementation such as the National Vitamin A Programme have been globally recognized as a successful programme, nutritional anaemia remains a public health issue among women, adolescents and children. Forty-one percent of women of reproductive age (58% in province 2) and 46 percent of pregnant women are anaemic. About 68 percent (NDHS 2016) of children aged 6-23 months are anaemic while the prevalence of that among adolescent women (15-19) has been increased from 38.5 percent in 2011 to 43.6 percent in 2016 (NDHS). According to NDHS 2016, 37% under five children are stunted in province 2 (national is 36%), 14.4% are wasted (national is 10%) and

36.8% are underweight (national is 27%). Similarly, 59% of children aged 6-59 months are anaemic in province 2 compared to 53% of Nepal.

Efforts to address under-nutrition

Several programmes are being implemented in Province to counter malnutrition. This began with growth monitoring and breastfeeding promotion followed by community-based micronutrient supplementation. Most recent national nutrition programmes have taken a food-based approach to promote improved dietary behaviour among vulnerable groups. MOHP/FWD's Nutrition Section and Ministry of Social Development (MoSD) has implemented the following programmes as in Table 5.

Table 5: Nutrition Program in Province 2

Nutrition programme under MOHP/FWD and MoSD in Province 2	
Provincewide programmes: • Growth monitoring and counselling • Prevention and control of Iron deficiency anaemia (IDA) • Prevention, control and treatment of vitamin A deficiency (VAD) • Prevention of iodine deficiency disorders (IDD) • Control of parasitic infestation by deworming • Mandatory flour fortification in large roller mills. • Infant and young child feeding (IYCF) • Integrated Management of Acute Malnutrition (IMAM)	**Scale-up programmes:** • Maternal, Infant, and Young Children Nutrition (MIYCN) programme • Micronutrient Powder (MNP) distribution linked with infant and young child Feeding (IYCF) • School Health and Nutrition Programme • Multi-sector Nutrition Plan (MSNP)-II

The overall objective of the national and provincial nutrition programme is to enhance nutritional well-being, reduce child, adolescents and maternal mortality and contribute to equitable human development.

The specific objectives of the programme are as follows:

- To reduce protein-energy malnutrition in children under 5 years of age and women of reproductive age
- To improve maternal nutrition
- To reduce the prevalence of anaemia among adolescent girls, women and children
- To eliminate iodine deficiency disorders and vitamin A deficiency and sustain 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 use of food needed for a 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 lifestyle related diseases including coronary disease, hypertension, tobacco related diseases, cancer and diabetes
- To improve the health and nutritional status of school children
- To reduce the critical risk of malnutrition and life during very difficult circumstances
- To strengthen the system for analyzing, monitoring and evaluating the nutrition situation

- Behaviour change communication and nutrition education at community levels
- To align health sector programmes on nutrition with the Multi-Sectoral Nutrition Initiative.

Targets

Current Global Nutrition Targets

a. Sustainable Development Goal

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

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

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

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

National Nutritional Status and Targets

Table 6: Nepal's progress against the MSNP 2 targets (2001–2016)

Indicators	***Status (%)***				***Target (%)***		
	NDHS 2001	**NDHS 2006**	**NDHS 2011**	**NDHS 2016**	**MSNP 2022**	**WHA 2025**	**SDG 2030**
Stunting among U5 children	57	49	41	36	28	24	15
Wasting among U5 children	11	13	11	10	7	<5	4
Underweight among U5 children	43	39	29	27	20	15	10
Percentage of LBW	-	14	12	12	10	≤1.4	≤1.4
Exclusive breastfed	-	53	70	66	80	85	90
Fed according to recommended IYCF practices	-	-	24	36	60	70	80
Over-weight and obesity among U5 children	-	-	-	2.1	1.4	1	<1
Anaemia among U5 children	-	48	46	53	28	20	<15
Anaemia among children under 6-23 months of age	-	78	69	68	-	35	<25
Anaemia among women (15-49)	-	36	35	41	24	20	<15
Anaemia among pregnant women	-	42	48	46	-	35	<25

Anaemia in adolescent girls (15-19)	-	39	38.5	43.6	25*	35	<25
Body mass index (<18.5 kg/m^2) among women	26	24	18.2	17	12	8	<5
Overweight or obese among women	-	9	14	22	18	15	<12

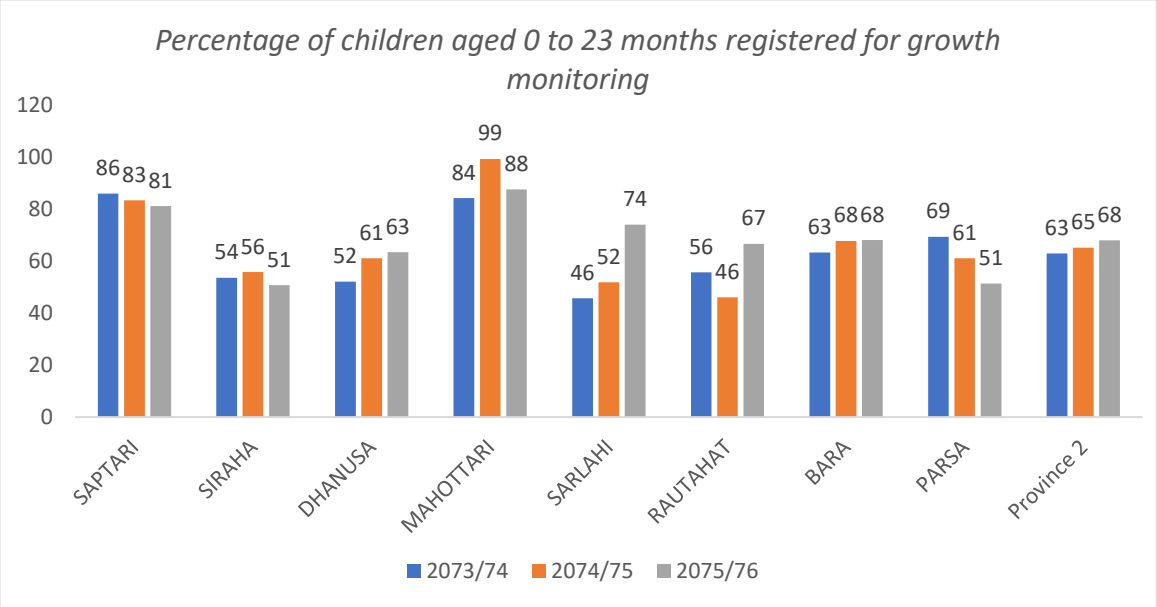
Anaemia in adolescent girls for 10-19 years aged

Major achievements

Growth monitoring and promotion

Monitoring the growth of children less than two years of age helps prevent and control protein-energy malnutrition and provides the opportunity for taking preventive and curative actions. Health workers at all public health facilities and at PHC ORC monitor the growth of children once a month using the growth monitoring card that is based on WHO's new growth standards.

Figure 17: Percentage of children aged 0-23 months registered for growth monitoring

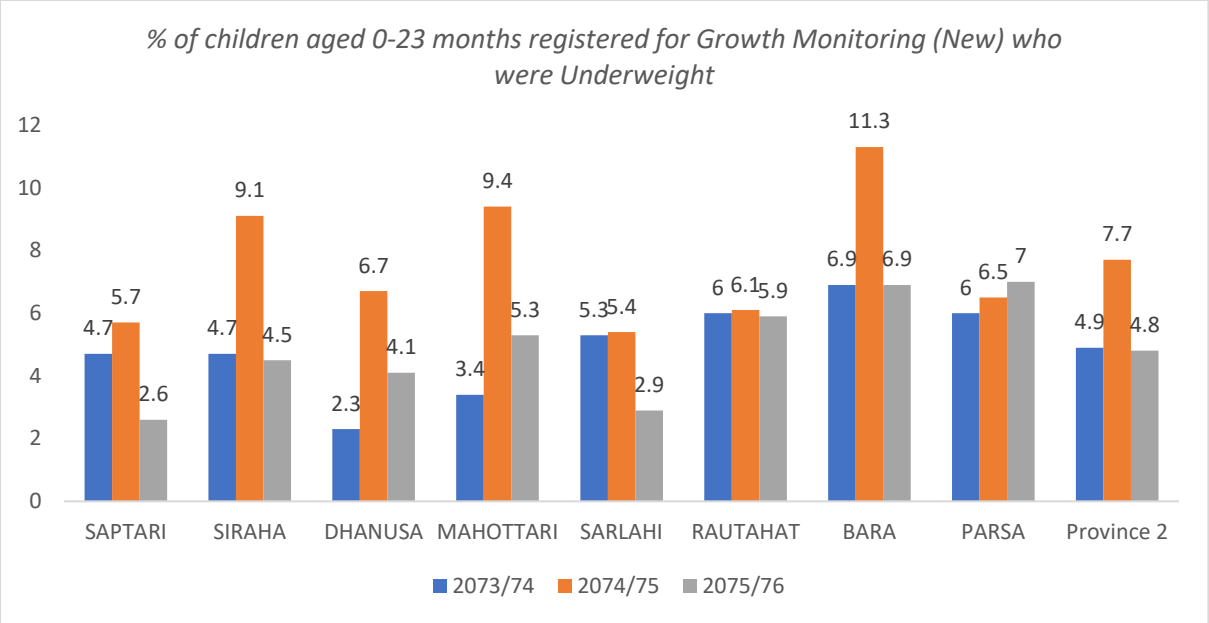


Source: HMIS Data

In province no-2, the percentage of children aged 0 to 23 months registered for growth monitoring in 2075/76 (68 per cents) was increased from the previous fiscal years. Across the districts, the percentage of growth monitoring is decreased in Saptari, Siraha, Mahottari and Parsa whereas increased in Dhanusa, Sarlahi, Rautahat and Bara districts. Among the increased the highest percentage is 74 % in Sarlahi and the lowest percentage is 63.4% in Dhanusa. PHC ORCs are being strengthened as the outreach site to increase the access for growth monitoring.

While looking into the age groups, the registered number of growth monitoring is increased in both age groups (0-11 months and 12-23 months) in province no -2. But across the districts this number has mix result. The registered number for growth monitoring among children 0-11 months is increased in Saptari, Dhanusa, Sarlahi, Rautahat and Bara districts and decreased in Siraha, Mahottari and Parsa districts. The registered number for growth monitoring among children 12-23 months is increased in Dhanusa, Sarlahi, Rautahat districts and decreased in Saptari, Siraha Mahottari, Bara and Parsa districts.

Figure 18: Percentage of children aged 0-23 months registered for growth monitoring (New) who were underweight



Source: HMIS Data

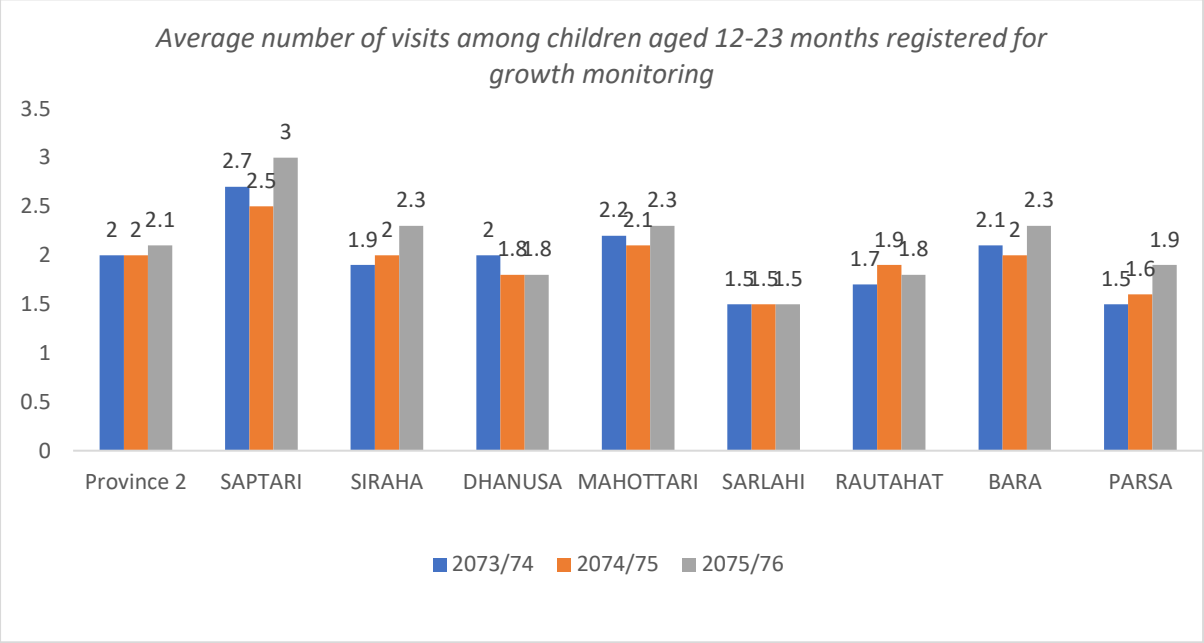
The percentage of children aged 0 to 23 months registered for growth monitoring who were underweight in 2075/76 (4.8 per cents) was decreased from the previous fiscal years. Across the districts, Bara district had the highest percentage (6.9%) while Saptari had the lowest percentage (2.6%) of children aged 0 to 23 months registered for growth monitoring in 2075/76 in the above Figure. The percentage of underweight is increased to 7 percent from 6.5 percent in FY 2074/75 and 6 percent in FY 2073/74 in Parsa district.

While looking into the age groups, in FY 2075/76 the percentage of both age groups (0-11 months and 12-23 months) registered for Growth Monitoring (New) who were underweight is decreased in all districts except unchanged in Rautahat (5.9% in 0-11 months) and increased in Parsa in all age groups compared to last year.

Average number of visits among children aged 12-23 months registered for growth monitoring

In Province no-2, the average no of visit among children aged 12-23 months registered for growth monitoring increased from 2 in FY 2074/75 to 2.1 in FY 2075/76. Across the districts the highest average visit is 3 in Saptari whereas the lowest is 1.5 in Sarlahi and is stagnant for last three consecutive years.

Figure 19: Average number of visits among children aged 12-23 months registered for growth monitoring



Source: HMIS Data

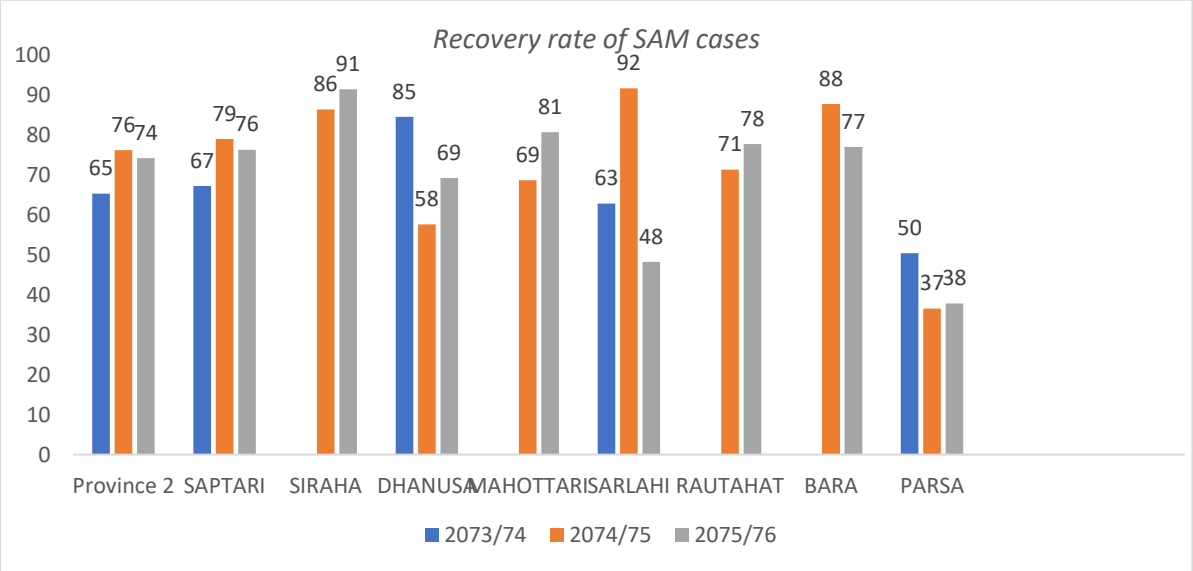
Number of cases admitted at outpatient therapeutic centers (OTPs)

In province no-2, the Number of cases admitted at outpatient therapeutic centers (OTPs) are decreased compared to last year (from 15292 to 4622). The situation is similar across all the 8 districts within the province no-2.

Recovery rate of SAM cases

In province no-2, there is decrease in percentage of recovery rate of SAM cases (from 76.2% in FY 2074/75 to 74.2% in FY 2075/76). Across the districts it is increased in Siraha, Dhanusa, Mahottari, Rautahat and Parsa and decreased in Saptari, Sarlahi and Bara districts.

Figure 20: Recovery rate of SAM cases

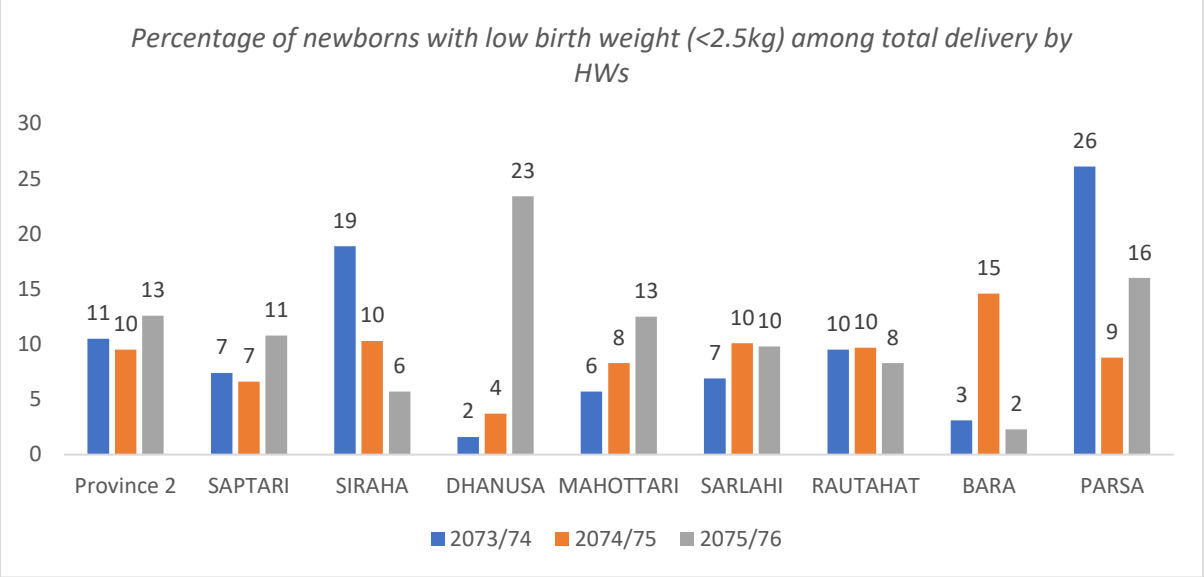


Source: HMIS Data

Percentage of newborns with low birth weight (<2.5kg) among total delivery by HWs

Percentage of newborns with low birth weight (<2.5kg) among total delivery by HWs increased (9.5% in 2074/75 to 12.6 % in 2075/76) in province no -2. Across the districts the percentage is increased in Saptari, Dhanusa, Mahottari and Parsa districts and decreased in Siraha, Sarlahi, Rautahat and Bara districts. Among the increased, the highest percentage is in Dhanusa (23.4%) followed by Parsa (16%) Mahottari (12.5%) and Saptari (10.8 %). The increased low birth weight may be due to the early marriage and malnutrition among the adolescent's girls and pregnant women.

Figure 21: Percentage of newborns with low birth weight (<2.5kg) among total delivery by HWs



Source: HMIS Data

Nutrition Rehabilitation Homes

Nutrition rehabilitation homes (NRH) aim to reduce child mortality caused by malnutrition through inpatient rehabilitation of acute malnutrition among the children. There are three NRH, Gajendra Narayan Singh Hospital, Janakpur Provincial Hospital and Narayani Sub-regional Hospital Birgunj in province 2. The NRH not only treat and manage acute malnutrition with inpatient service, but also provide nutrition education and counselling to the guardians of admitted children on good nutrition and health care of their children.

Nutritional Rehabilitation Homes restore severely malnourished children to good health while educating their mothers about nutrition and childcare. When mother and child return to their village, the mother shares their new knowledge with their family and neighbours. This program is very effective which involves the mothers in the process for built-in sustainability to bring back children's optimal health.

Prevention and control of iron deficiency anaemia

MoHP has been providing iron folic acid (IFA) supplementation to pregnant and post-partum women since 1998 to reduce maternal anaemia. The protocol is to provide 60 mg elemental iron and 400 microgram folic acid to pregnant women for 225 days from their second trimester. To improve access, in 2003, the Intensification of Maternal and Neonatal Micronutrient Programme (IMNMP) began IFA supplementation through female community health volunteers (FCHVs). This programme covered all 8 districts of province 2. The intensification programme improved coverage, although compliance with taking 180 tablets during pregnancy and 45 tablets post-partum remains an issue. The table below shows the percentage of pregnant women received 180 tablets Iron in FY 2075/76 in province and districts.

Table 7: Percentage of pregnant women received 180 tablets Iron

Province	Saptari	Siraha	Dhanusha	Mahottari	Sarlahi	Rautahat	Bara	Parsa
56.5	64.5	108.5	32.2	68.8	52.4	58.5	33.7	34.6

Source: HMIS Data

Infant and Young Child Feeding and Micro-Nutrient Powder Community Promotion Programme

The NDHS 2006 found that 78 percent of 6-23 months old children were anaemic, mostly due to poor IYCF practices. A Plan of Action subsequently endorsed Sprinkles as the key intervention to address anaemia in young children. In 2007, the National Nutrition Priority Workshop endorsed the piloting of sprinkles supplementation as a preventive measure.

The promotion of MNPs is linked with improving complementary feeding. Mothers and caregivers are counselled to introduce complementary foods at six months of age, on age-appropriate feeding frequency, on improving dietary quality of complementary foods by making them nutrient and calorie dense, as well as on hand washing with soap before feeding. Mothers and caregivers are trained to prepare 'poshilo jaulo' (pulses, rice and green vegetables cooked in oil) and 'lito' (mixture of blended and roasted cereal and legume flours). A feasibility study of the programme in 2008/09 found strong community acceptance with a very high coverage and compliance on the use of MNP. The linking of IYCF with MNPs has contributed to significant improvement in IYCF practices. The prevalence of anemia among children age 6-23 months has decreased to 68% (NDHS, 2016) from 78 percent. However, it still calls for continuous effort as the coverage of the program is not very promising.

This programme was only in Parsa before 2018. In 2018, the programme was scaled up in additional six districts namely Bara, Rautahar, Sarlahi, Mahottary, Dhanusa and Saptari.

S.N.	Districts/Province	% 6-23 months children taking 1st cycle of MNP	% 6-23 months children taking 3rd cycle of MNP
1.	Saptari	36.6	5.5
2.	Dhanusha	30.5	0.6
3.	Mahottari	40.8	0.8
4.	Sarlahi	27.1	1.2
5.	Rautahat	34	2.2
6.	Bara	45.9	4.5
7.	Parsa	38.9	12
	Province No. 2	**31.9**	**3.2**

Control of vitamin A deficiency disorders

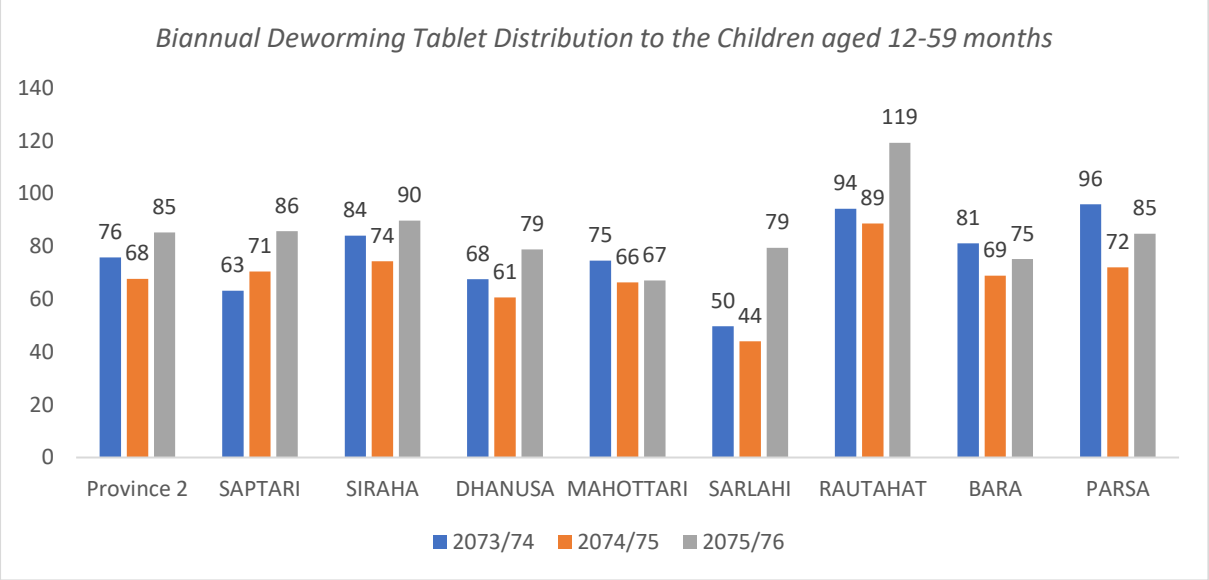
The government initiated the National Vitamin A Programme in 1993 to improve the vitamin A status of children aged 6-59 months and reduce child mortality. This programme is recognized as a global public health success story. It initially covered 8 districts and was scaled up nationwide by 2002 including all eight districts of Province 2. FCHVs distribute the capsules to the targeted children twice a year through a campaign-style activity in the first week of Baishakh and Kartik.

Biannual Deworming Tablet Distribution to the Children aged 12-59 months

Biannual deworming tablets are distributed to the children aged 12-59 months aiming to reduce childhood anaemia with control of parasitic infestation through public health measures. This activity is integrated with biannual Vitamin A supplementation to the children aged 6-59 months, which takes place nationally on first week of Baisakh and Kartik each year. Deworming to the target children was initiated in few districts during the year 2000 integrating with biannual Vitamin A supplementation

and with gradual scaling-up, the program was successfully implemented nationwide by the year 2010 including all the eight districts of Province 2.

Figure 22: Biannual Deworming Tablet Distribution to the Children aged 12-59 months



Source: HMIS Data

School Health and Nutrition Programme

The School Health and Nutrition Strategy (SHNS) was developed jointly in 2006 by Ministry of Health and Ministry of Education to address the high burden of diseases in school age children. In 2008, a five-year Joint Action Plan (JAP) was endorsed to implement School Health and Nutrition (SHN) Program.

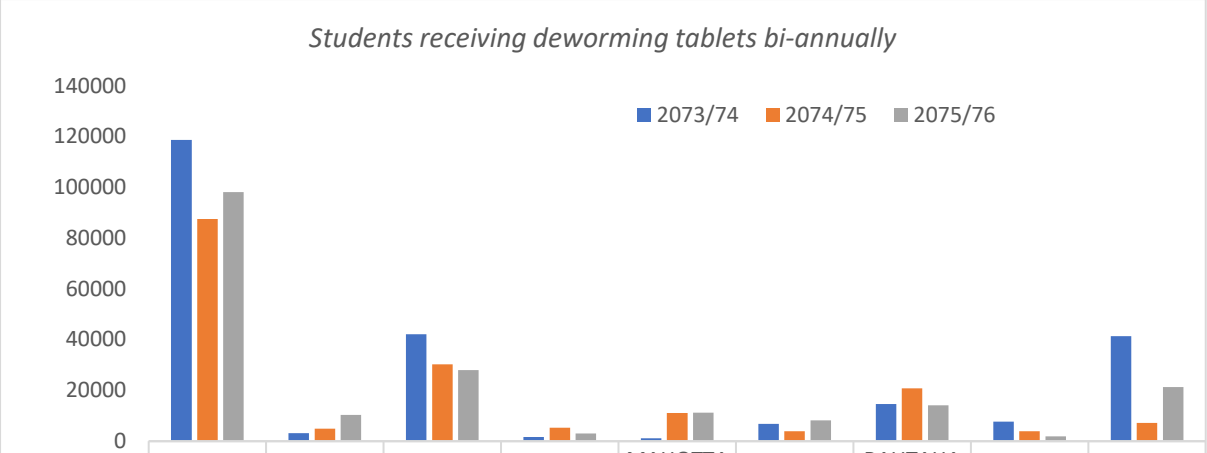
The improved use of school-based health and nutrition services, improved access to safe drinking water and sanitation, skill-based health education, community support and an improved policy environment are the core elements of the School Health and Nutrition Programme.

During 2008-2012, government had implemented a pilot SHN project in primary schools based on the Joint Action Plan in Sindhupalchowk and Syangja districts. This pilot project has some promising results recommending to scale up the program in other districts. In province 2, adolescent Iron Folic Acid supplementation is one of the components of SHNS which was introduced in 2018 in all districts except Siraha district (targeting to introduce in next fiscal year). The current Joint Action Plan (2071/072 to 2075/76) calls for:

- annual health screening
- biannual deworming of Grade 1–10 school children
- a first aid kit box with refilling mechanism in all primary schools
- hand washing facilities with soap in all schools
- toilets in all schools
- the use of the new attendance registers in all schools
- orient school management committees on facilitating health and nutrition activities
- child club mobilization on health and nutrition issues.

One of the major activities under SHN Program is Biannual School Deworming to all the School- aged children (SAC) that is conducted in first week of Jestha and Mangsir every year.

Figure 23: Students receiving deworming tablets bi-annually



	Province 2	SAPTARI	SIRAHA	DHANUSA	MAHOTTARI	SARLAHI	RAUTAHAT	BARA	PARSA
2073/74	118718	3131	42196	1659	1199	6843	14620	7673	41397
2074/75	87497	4979	30255	5349	11111	3895	20777	3897	7234
2075/76	98148	10335	28028	3012	11229	8161	14179	1902	21302

Source: HMIS Data

The figure above shows the cumulative number of students receiving deworming tablets bi-annually in province 2. The number of students receiving deworming tablets increased from 87497 to 98148 from last fiscal year 2074/75.

The number has been decreased in Siraha, Dhanusha, Rautahat and Bara district compared to last fiscal year 2074/75, whereas the remaining districts have increased trend compared to last fiscal year. The decline might be due to incomplete reporting from the schools as well as underreporting.

Adolescent Iron Folic Acid supplementation program in school of grade 6-12 adolescent girls is another major activity under SHN program implemented in all districts of province 2 except Siraha district which was introduced in 2018. Number of adolescent girls (grade 6-12 children of age 10-19 years) provided with weekly Iron Folic Acid supplementation at least once were 130596 in 2019 AD.

Emergency Response in Tornado

On 31 March 2019, night, tornado hit several places in southern part of Bara and Parsa districts in Province 2. The tornado had high impact in Feta Rural Municipality, Parwanipur Rural Municipality, Subarna Rural Municipality, Pacharauta Rural Municipality, Prasauni Rural Municipality, Mahagadhimai Rural Municipality, Devtal Rural Municipality and Kalaiya Sub Metropolitan City ward no 10 and 12 of Bara district and Bahudarmai Rural Municipality, Thori Rural Municipality and Birgunj Metropolitan City Ward no 22 of Parsa district.

According to Ministry of Home Affairs, 27 death cases were reported in Bara and one death was reported in Parsa district. A total of 678 people was injured and treated in different hospitals of Bara and Parsa.

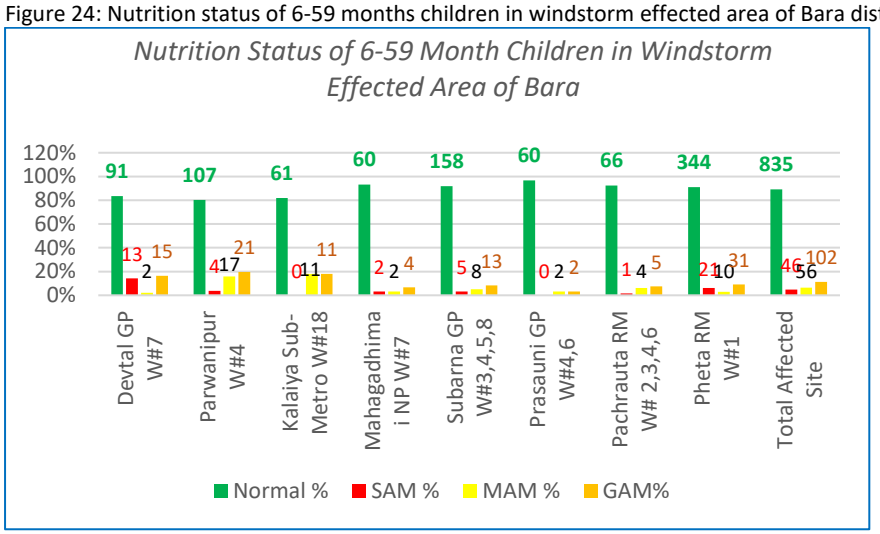
Twenty-eight people (male 13, female 15 including six children - two boys and four girls), lost their lives and 1,155 people were injured (http://drrportal.gov.np/). 2,404 houses were damaged (1,062 completely and 1,342 partially) and 7,328 people were temporarily displaced in Bara and 671 in Parsa districts respectively.

In both Bara and Parsa a total of 2404 houses (1062 complete, and 1342 partially) including three schools were damaged. The flattened structures were mostly *kaccha* bamboo houses, and structures

with thatch roof and corrugated sheet roof. According to IRA, total affected number of people in Bara district was 15,301 (2782 families) and Parsa was 2800 (509 families) and displaced people were7328 in Bara and 671 in Parsa. Health post of Pheta Gaupalika, ward no 6, Purania was damaged, the roof was blown out. Health services were provided through health camps and tents provided by UNICEF and UNFPA.

Nutrition status of 6-59 months children was carried out by the health workers in tornado affected areas of Bara district which is shown in the Figure.24

Figure 24: Nutrition status of 6-59 months children in windstorm effected area of Bara district



Issues, constraints and recommendations

Table 8: Issues, constraints and recommendations— Nutrition programme

Issues and constraints	Recommendations	Responsibilities
• Incomplete reporting through HMIS • Lack of HMIS tools and recording i.e. registers and monthly monitoring sheets	• HWs should use and complete the recording and reporting HMIS tools	• Palika, Health Office, • Health Directorate
• Growth monitoring sessions not carried out regularly	• PHC/ORC should be functional, regular and equipped	• Palika, Health Office
• Inadequate OTC centers to manage SAM children	• Require essential commodities to be supplied	,,
• Nominal follow up of malnourished children and mothers	• FCHVs and HWs should focus on follow up	,,
• Lack of regular screening of malnutrition in children, adolescent and women of reproductive age	• At least bi-annual screening should be included in regular programmes	,,

2.3 INTEGRATED MANAGEMENT OF NEONATAL AND CHILDHOOD ILLNESSES

2.3.1 Introduction

A chronological development: Community Based-Integrated Management of Childhood Illness (CB-IMCI), Community Based Integrated Management of Newborn Care Program (CB-NCP) and Community Based-Integrated Management of Neonatal and Childhood Illness (CB-IMNCI)

In Nepal, Child survival intervention began when Control of Diarrhoeal Disease (CDD) Program was initiated in 1983. Further, Acute Respiratory Infection (ARI) Control Program was initiated in 1987. To maximize the ARI-related services at the household level, referral model and treatment model at the community level were piloted. An evaluation of this intervention in 1997 revealed that treatment model was more effective and popular in the community than referral model. In 1997/98, ARI intervention was combined with CDD and named as CB-AC program. One year later two more components, nutrition and immunization, were also incorporated in the CBAC program. IMCI program was piloted in Mahottari district and was extended to the community level as well. Finally, the government decided to merge the CBAC into IMCI in 1999 and named it as Community- Based Integrated Management of Childhood Illness (CB-IMCI). CB-IMCI included the major childhood killer diseases like pneumonia, diarrhoea, malaria, measles, and malnutrition. The strategies adopted in IMCI were improving knowledge and case management skills of health service providers, overall health systems strengthening and improving community and household level care practices. After piloting of low osmolar ORS and Zinc supplementation, it was incorporated in CB- IMCI program in 2005. Nationwide implementation of CB-IMCI was completed in 2009 and revised in 2012 incorporating important new interventions.

Up to 2005, Nepal had made a huge progress in reduction of under-five and infant mortality, however, the reduction of neonatal mortality was observed very sluggish because the country had no targeted interventions for newborns especially at community level. State of world report, WHO showed that major causes of mortality were infections, asphyxia, low birth weight and hypothermia. The Government of Nepal formulated the National Neonatal Health Strategy 2004. Based on this 'Community-Based New Born Care Program (CB-NCP)' was designed in 2007, and piloted in 2009. CB-NCP incorporated seven strategic interventions: behaviour change communication, promotion of institutional delivery, postnatal care, management of neonatal sepsis, care of low birth weight newborns, prevention and management of hypothermia and recognition and resuscitation of birth asphyxia. Furthermore, in September 2011, Ministry of Health and Population decided to implement the Chlorhexidine (CHX) Digluconate (7.1% w/v) aiming to prevent umbilical infection of the newborn. The government decided to scale up CB-NCP and simultaneously, the program was evaluated in 10 piloted districts. Upto 2014, CB-NCP was implemented in 41 districts covering 70% population.

As a result of CB-IMCI program strategy, the prevalence of pneumonia and diarrhoea has reduced significantly over the last decades. The care-seeking practices and household level practices have been improved. CB-IMCI program has become one of the role models for a community-based program of Nepal. Other interventions which have a high contribution to the reduction of post- neonatal child mortality are bi-annual supplementation of Vitamin A program, expanded program on immunization. On the other hand, essential newborn care practices were improved in CB-NCP implemented districts.

In both of the programs (CB-IMCI and CB-NCP), FCHVs were considered as frontline health service providers but quality and coverage of service were very low. CB-NCP and CB-IMCI have similarities in interventions, program management, service delivery and target beneficiaries. Both programs have duplicated interventions like management of neonatal sepsis, promotion of essential newborn care practices, infection prevention, and management of low birth weight. Though FCHVs are doing very

good on the promotion of healthy behaviours, they are found poorly performing in service delivery. Moreover, they are overburdened with workloads and massive resource was used in a fragmented manner for the same purpose. Also, inequity in quality service delivery and utilization are the major challenges in newborn and child health programs. Health governance issue is also affecting to better functioning of the health system. Considering the management of similar kind of two different programs, MoH decided to integrate CB-NCP and IMCI into a new package that is named as CB-IMNCI.

2.3.1.1 Community-Based Integrated Management of Newborn and Childhood Illnesses (CB-IMNCI)

CB-IMNCI is an integration of CB-IMCI and CB-NCP Programs as per the decision of MoH on 2071/6/28 (October 14, 2015). This integrated package of child-survival intervention addresses the major problems of sick newborn such as birth asphyxia, bacterial infection, jaundice, hypothermia, low birth-weight, counseling of breastfeeding. It also maintains its aim to address major childhood illnesses like Pneumonia, Diarrhoea, Malaria, Measles and Malnutrition among under 5 year's children in a holistic way.

In CB-IMNCI program, FCHVs are expected to carry out health promotional activities for maternal, newborn and child health and dispensing of essential commodities like distribution of iron, zinc, ORS, chlorhexidine which do not require assessment and diagnostic skills, and immediate referral in case of any danger signs appeared among sick newborn and children. Health workers will counsel and provide the health services like management of non-breathing cases, low birth weight babies, common childhood illnesses, and management of neonatal sepsis. Also, the program has provisioned for the post-natal visits by trained health workers through primary health care outreach clinic.

Development of IMNCI training site has already been started. The program has envisioned that CHD will act as the quality assurance and monitoring entity for the CB-IMNCI program. Clinical training sites and RHTC will be the lead agency for training in near future. IMNCI section has been focusing on the phase-wise implementation of the program with continuous monitoring and supportive supervision to strengthen the program and onsite coaching to enhance the clinical skill among health workers. CB-IMNCI program has been implemented in 75 districts, including all 8 districts under Province No. 2.

2.3.1.2 Facility-Based Integrated Management of Childhood and Neonatal Illnesses

The Facility-Based Integrated Management of Neonatal and Childhood Illnesses (FB-IMNCI) package has been designed specially to address childhood cases referred from peripheral level health institutions to higher institutions. The package is linked strongly with the on-going Community Based Integrated Management of Neonatal and Childhood Illness (CB-IMNCI). The package is expected to bridge the existing gap in the management of complicated neonatal and childhood illnesses and conditions. With the gradual implementation of this package, further improvement in neonatal and child health can be expected. This package addresses the major causes of childhood illnesses including Emergency Triage and Treatment (ETAT) and thematic approach to common childhood illnesses towards diagnosis and treatment especially newborn care, cough, diarrhoea, fever, malnutrition and anaemia.

2.3.1.3 Comprehensive Newborn Care Training package

As indicated by various evidences, extra efforts are necessary for overcoming barriers to accelerate the reduction in neonatal mortality. As a result of the step towards reducing these newborn deaths, "Comprehensive Newborn Care Training Package (For Level II Hospital Care)" was developed in order to provide training to paediatricians, senior medical officers and medical officers working in the hospitals providing level II care services. This training is being conducted in the Province with lead role from Family Welfare Division

2.3.1.4 Free Newborn Care Services

The Government of Nepal (GoN) has made provisions on treating sick newborn free of cost through all tiers of its health care delivery outlets. The aim of this program is to prevent any sorts of deprivation to health care services of the newborn due to poverty. Based on the treatment services offered to the sick-newborn, the services are classified into 3 packages: A, B and C. The newborn corners in health posts and PHCs offer Package 'A', district hospitals with Special Newborn Care Unit (SNCU) offer Package 'B' and zonal hospitals and other tertiary hospitals offering Neonatal Intensive Care Unit (NICU) provide services for Package 'C'. The government has made provisions of required budget and issued directives to implement the free newborn care packages in Nepal. The goal of the Free Newborn Care Service Package is to achieve the sustainable development goal through increasing access of the newborn care services to reduce newborn mortality. The program makes the provision of disbursing **Cost of Care** to respective health institutions required for providing free care to inpatient sick newborns.

2.3.2 Goals, targets, objectives, strategies, interventions and activities of IMNCI program

Goal

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

Targets of Nepal Health Sector Strategy (2015-2020)

- Reduction of Under-five mortality rate (per 1,000 live births) to 28 by 2020
- Reduction of Neonatal mortality rate (per 1,000 live births) to 17.5 by 2020

Objectives:

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

Strategies

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

Major interventions

Newborn Specific Interventions

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

Child Specific Interventions

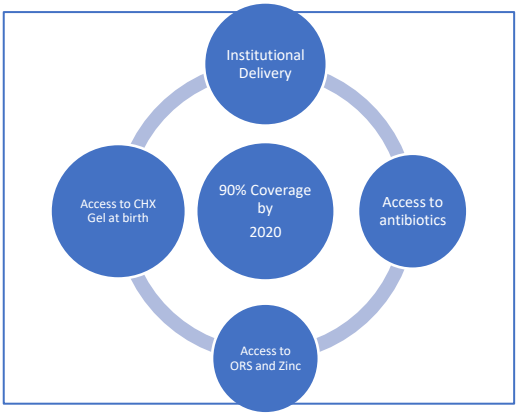
- Case management of children aged between 2-59 months for 5 major childhood killer diseases (Pneumonia, Diarrhoea, Malnutrition, Measles and Malaria)

Cross -Cutting Interventions

- Behaviour change communications for healthy pregnancy, safe delivery and promote personal hygiene and sanitation
- Improved knowledge related to Immunization and Nutrition and care of sick children
- Improved interpersonal communication skills of HWs and FCHVs

Vision 90 by 20

CB-IMNCI program has a vision to provide targeted services to 90% of the estimated population by 2020 as shown in the diagram on the right.



Major activities

Major activities carried out under the IMNCI programme in FY 2074/75 were as follows:

- Training on FB-IMNCI to paramedics, nurses and doctors
- Procurement of commodities and equipment related to IMNCI
- Establishment/Strengthening of SNCU

CB-IMNCI Program Monitoring Key Indicators

Regular monitoring is important for better management of program. Therefore, CB-IMNCI program has identified 6 major indicators to monitor the programs that are listed below:

- % of Institutional delivery
- % of newborn who had applied Chlorhexidine gel immediately after birth (within one hour)
- % of infants (0-2 months) with PSBI receiving complete dose of Injection Gentamicin
- % of under 5 children with pneumonia treated with antibiotics
- % of under 5 children with diarrhoea treated with ORS and Zinc
- Stock out of the 5 key CB-IMNCI commodities at health facility (ORS, Zinc, Gentamicin, Amoxicillin/Cotrim, CHX)

All indicators except number six are related to HMIS**.** It is expected that if there is high institutional delivery, there would be good essential newborn care and immediate management of complications like birth asphyxia that will ultimately contribute to reduce the neonatal mortality. The 2073/74 monitoring results of the CB-IMNCI programme were as follows (Table 9).

Table 9: CB-IMNCI programme monitoring indicators by district (FY 2075/76)

District	*% of institutional deliveries*	*% of newborn applied chlorhexidine (CHX) gel*	*% PSBI cases received complete dose Inj. Gentamicin*	*% of pneumonia cases treated with antibiotics*	*% diarrhoeal cases treated with ORS and zinc*
Saptari	37.5	52.0	4.5	365.5	96
Siraha	40.9	38.2	19.1	186	96.1
Dhanusha	74.5	57.5	10.4	125.9	92.6
Mahottari	27.9	36.1	185.7	236.1	150.3
Sarlahi	50.4	49.1	111.1	145.8	94.8
Rautahat	47.7	32.9	21.9	204.4	106.4
Bara	37.1	23.5	48.9	464.7	100.4
Parsa	109.5	82.0	59.1	215.5	90.4
Province No. 2	**52.7**	**46.0**	**58.8**	**203**	**102.3**
National	**61.2**		**46.2**	**136.5**	**95.7**

Source: HMIS/MD/DoHS

Provincial average for institutional deliveries in FY 2075/76 was 61.2 percent which is an significant from 34.4 percent in FY 2074/75. District-wise, the lowest performance was observed in Mahottari at

27.9 percent and highest in Parsa at 109.5 percent. Chlorhexidine was applied in 36.71 percent newborn's umbilicus among total expected live births. The average use of CHX was highest in Parsa (82%) and lowest in Bara (23.5%).

Compliance of injection Gentamicin at national level for PSBI cases among under two months child was just 46% which is nearly half of last FY's performance at 84.93 percent. Wide variation between districts performances depicts the general unreliability of the data reported, indicated by data of 4.5 percent in Saptari to 185.7% in Mahottari, which is difficult to interpret. The data was so faulty that no analysis can be carried out based on it.

Likewise, the indicator of percentage of pneumonia cases (as reported in HMIS) who received treatment with antibiotics was more than 100% in all 8 districts, some even ranging to as much as 465%. This is probably because the treatment of all the cases by antibiotics other than pneumonia was also added like skin infection, ear infection etc. which is actually a reporting error. No analysis can be carried out based on the given data, because one cannot say for sure what percentage of real pneumonia cases actually received the treatment (even though the indicator may be more than 100%).

As per CB-IMNCI treatment protocol, all diarrhoeal cases should be treated with ORS and Zinc. Based on HMIS data, U5 children suffering from diarrhoea treated with ORS and Zinc at Provincial level was 95.7 percent, which was highest in Mahottari (150.3%) and lowest in Parsa (90.4%). While achievement above 100% is by itself unexplainable, it is worth noting that NDHS 2016 had reported that the percent of under-five years children treated ORS and Zinc in Province no. 2 was just 3.3% (lowest of 7 provinces) while the national average was 10.3%.

2.3.3 Achievements

Since FY 2064/65, CB-IMCI services data (as received from Health Facilities, VHWs/MCHWs and FCHVs) has been incorporated into HMIS. Therefore, from FY 2064/65 onwards, service provided at community level (PHC/ORCs and FCHVs) is considered as community level data whereas total service provided from Health Facility level in addition with community level constitutes the aggregated data for this program. CB-IMNCI program has been initiated from FY 2071/72 and from FY 2071/72 Health Facility Level and Primary Health Care/Out Reach Clinics (PHC/ORC) data has been incorporated into HMIS. Consequently, the role of FCHV at community level has been redefined and limited to counselling service for newborn care. Obviously, the treatment protocol has also been changed and role of FCHVs at the community level has been assigned as health promoters/counsellors rather than health service providers. As per the new reporting and recording system, the achievements of management of under 5 children are given in the table below.

2.3.3.1 Management of newborns (0-59 days)

Table 10: Classification and treatment of 0-59 day newborn cases by district (FY 2073/74 – 75/76)

Indicators	FY	Saptari	Siraha	Dhanusha	Mahottari	Sarlahi	Rautahat	Bara	Parsa	Province 2	
										Number	%among total cases
Total cases	2073/74	249	28	89	303	8	1025	22	492	2216	
	2074/75	147	205	170	265	99	611	109	522	2128	
	2075/76	200	91	213	379	93	441	186	180	1783	
Possible severe bacterial infections (PSBI)	2073/74	8	0	2	9	0	26	1	17	63	2.8
	2074/75	3	2	9	2	6	33	6	17	78	3.7
	2075/76	4	8	5	12	1	39	9	21	99	5.6
Local bacterial infections	2073/74	197	9	67	294	6	850	16	277	1716	77.4
	2074/75	77	84	108	140	28	425	58	333	1253	58.9
	2075/76	66	26	152	326	53	342	95	124	1184	66.4
Jaundice	2073/74	1	0	0	3	1	8	0	32	45	2.0
	2074/75	0	0	3	5	0	4	3	39	54	2.5
	2075/76	1	0	5	0	0	7	0	2	15	0.8
Referred	2073/74	9	1	0	12	0	42	3	16	83	3.7
	2074/75	26	8	15	15	8	42	15	44	173	8.1
	2075/76	6	29	31	28	6	35	4	5	144	8.1
Deaths	2073/74	1	0	0	0	0	0	0	1	2	0.1
	2074/75	0	0	0	0	0	0	0	0	0	0
	2075/76	0	0	0	0	0	11	0	0	11	0.6
FCHVs											
Sick baby	2073/74	666	745	420	1022	390	1847	379	576	6045	
	2074/75	561	811	493	897	276	1469	550	680	5737	
	2075/76	675	756	630	1265	840	1373	569	815	6923	

Source: HMIS/MD/DoHS

In FY 2075/76, a total of 1,783 newborns cases were registered and treated at health facilities and PHC/ORC level. A serious challenge to the program can be assumed from the fact that, as per DHIS2 reports, all these cases were from PHC-ORCs, and none of the HFs in the province have reported of treating a single sick child below 2 months of age. Out of the treated cases, Rautahat district had highest number of registered cases followed by Parsa and least cases treated was in Sarlahi. Out of total registered cases in FY 2075/76, just 99 cases were classified as Possible Severe Bacterial Infection (PSBI) which accounts for 5.6 percent at provincial level and among the total registered cases the proportion of PSBI was highest in Rautahat (39%) followed by Parsa (21%). However, the analysis based on the given indicators should be made carefully because of the minimal number of cases identified and treated in all the districts (a mere 39 and 21 in Rautahat and Parsa respectively). Among the total registered cases at the provincial level, 66 percent cases were classified as LBI and 0.8 percent as Jaundice. Among the total registered cases the proportion of LBI was highest in Mahottari (86%)

followed by Rautahat (78%). Out of all the cases identified 8 percent cases were referred. A point worth noting is that only Rautahat district reported newborn deaths (11 newborn deaths).

Total 6,923 cases were identified by FCHVs as sick children below 2 months of age almost 20 percent (1373) was reported by Rautahat alone. Also a point to be noted is that Rautahat has been consistently reporting highest number of newborn cases identified by FCHVs or at health facilities over last 3 years.

2.3.3.2 Management of 2-59 months children

Diarrhoea

Classification of diarrhoeal cases by districts FY 2074/75

CB-IMNCI program has created enabling environment to health workers for better identification, classification and treatment of diarrhoeal diseases. As per CB-IMNCI national protocol, diarrhoea has, based on dehydration, been classified and treated as, 'No Dehydration', 'Some Dehydration', and 'Severe Dehydration'; based on the reported number and classification of total new diarrhoeal cases has been presented in Table 11 below.

Table 11: Classification of diarrhoeal cases by districts (FY 2075/76)

Indicators			*FY*	*Saptari*	*Siraha*	*Dhanusha*	*Mahottari*	*Sarlahi*	*Rautahat*	*Bara*	*Parsa*	*Province No. 2*
Diarrhoeal cases (HF + PHC-ORC)	Total		2073/74	12440	11657	11813	10024	6456	15819	10845	9767	88,821
			2074/75	13390	13359	11378	10286	9450	15551	11446	9587	94,447
			2075/76	13029	12746	12527	9831	12469	15640	11551	9356	97,149
	No dehydration (out of total diarrhoeal cases)	#	2073/74	9831	8512	9906	7543	5200	11919	9416	7239	69566
		%	2073/74	28.3	19.7	31.1	31.7	18.6	25.0	19.1	22.5	24.9
		#	2074/75	10815	9776	9000	7605	7689	12245	9812	7260	74202
		%	2074/75	80.8%	73.2%	79.1%	73.9%	81.4%	78.7%	85.7%	75.7%	78.6%
		#	2075/76	10735	9669	10211	7446	9625	12393	10249	7251	77,579
		%	2075/76	82.4	75.9	81.5	75.7	77.2	79.2	88.7	77.5	79.9
	Some dehydration	#	2073/74	2601	3106	1905	2473	1243	3724	1403	2482	18937
		%	2073/74	20.9	26.6	16.1	24.7	19.3	23.5	12.9	25.4	21.3
		#	2074/75	2535	3545	2307	2669	1701	3199	1626	2276	19858
		%	2074/75	18.93%	26.54%	20.28%	25.95%	18.00%	20.57%	14.21%	23.74%	21.03%
		#	2075/76	2284	2994	2294	2353	2786	3153	1270	2075	19209
		%	2075/76	17.5	23.5	18.3	23.9	22.3	20.2	11.0	22.2	19.8
	Severe dehydration	#	2073/74	8	39	2	8	13	176	26	46	318
		%	2073/74	0.06	0.33	0.02	0.08	0.20	1.11	0.24	0.47	0.36
		#	2074/75	40	38	71	12	60	107	8	51	387
		%	2074/75	0.30%	0.28%	0.62%	0.12%	0.63%	0.69%	0.07%	0.53%	0.41%
		#	2075/76	10	83	22	32	58	94	32	30	361
		%	2075/76	0.08	0.65	0.18	0.33	0.47	0.60	0.28	0.32	0.37
FCHV (diarrhoeal cases)		#	2073/74	16481	18667	16399	13096	7984	14620	15938	13471	116656
		%	2073/74	14.1	25.7	0.0	25.7	26.7	25.1	20.7	12.9	100
		#	2074/75	9640	11259	8967	7997	8212	11925	10127	7353	75480
		%	2074/75	12.8	14.9	11.9	10.6	10.9	15.8	13.4	9.7	100
		#	2075/76	17079	18495	14950	11909	16370	14670	14712	11495	119,680
		%	2075/76	14.3	15.5	12.5	10.0	13.7	12.3	12.3	9.6	100

Total diarrhoeal cases (HF andCommunities)	#	2073/74	28921	30324	28212	23120	14440	30439	26783	23238	205477
	%	2073/74	14.1	14.8	13.7	11.3	7.0	14.8	13.0	11.3	100
	#	2074/75	23030	24618	20345	18283	17662	27476	21573	16940	169927
	%	2074/75	13.6	14.5	12.0	10.8	10.4	16.2	12.7	10.0	100.0
	#	2075/76	30108	31241	27477	21740	28839	30310	26263	20851	216,829
	%	2075/76	13.9	14.4	12.7	10.0	13.3	14.0	12.1	9.6	100

Source: HMIS/MD/DoHS

In FY 2075/76, a total of 216,829 diarrhoeal cases were reported out of which about 44.8 percent were reported from health facilities and ORCs and 55.2 percent by FCHVs. Among cases registered in HFs and ORCs (97,149), about four-fifth (79.9%) were classified as having no dehydration. Severe dehydration among registered diarrhoeal cases remained below 1% in the province.

Table 12: Incidence and case fatality of diarrhoea among children under 5 years of age by districts (FY 2074/75)

Indicators	***FY***	***Saptari***	***Siraha***	***Dhanusha***	***Mahottari***	***Sarlahi***	***Rautahat***	***Bara***	***Parsa***	***Province No. 2***
Estimated <5 year population that are prone to diarrhoea	2073/74	70675	70083	83738	70133	87703	81102	80276	69651	613361
	2074/75	71052	70386	84221	70626	88634	82447	81438	70580	619384
	2075/76	71328	70590	84582	71026	89439	83701	82514	71415	624595
Incidence of diarrhoea/1,000 <5 yrs population	2073/74	409	433	337	330	165	375	334	334	335
	2074/75	324.1	349.8	241.6	258.9	199.3	333.3	264.9	240.0	274.3
	2075/76	422	443	325	306	322	362	318	292	347
Diarrhoeal deaths	2073/74	0	0	0	0	8	0	8	0	16
	2074/75	2	2	0	0	10	0	0	0	14
	2075/76	2	2	0	0	0	0	0	0	4
Case fatality rate per 1000	2073/74	0	0	0	0	0.091	0	0.099	0	0.026
	2074/75	0.087	0.081	0.000	0.000	0.566	0.000	0.000	0.000	0.082
	2075/76	0.066	0.064	0	0	0	0	0	0	0.018

Source: HMIS/MD/DoHS

Incidence of diarrhoea per thousand children under-five years of age was 347 in the Province which is significantly more than 274 in the last FY. District-wise, Saptari and Siraha have the highest prevalence at 422 and 443 resp. while Parsa has the lowest incidence 292. Diarrhoeal deaths reported, however has reduced, which was 4 in the last FY at Province level.

Treatment of diarrhoea

Table 13: Treatment of diarrhoea cases by districts

Indicators	***FY***	***Siraha***	***Saptari***	***Dhanusha***	***Mahottari***	***Sarlahi***	***Rautahat***	***Bara***	***Parsa***	***Province No. 2***
Total cases (HF+ORC+FCHV)	2073/74	28921	30324	28212	23120	14440	30439	26783	23238	205477
	2074/75	23030	24618	20345	18283	17662	27476	21573	16940	169927
	2075/76	30108	31241	27477	21740	28839	30310	26263	20851	216,829
Diarrhoeal cases treated with ORS and	2073/74 (#)	27483	26992	24226	21883	14253	30678	27183	22008	194706
	2073/74 (%)	95.0	89.0	85.9	94.6	98.7	100.8	101.5	94.7	94.8

zinc	2074/75 (#)	25283	22662	22690	17115	16347	25650	21790	17634	169171
	2074/75 (%)	109.8	92.	111.5	93.6	92.6	93.4	101.0	104.1	99.6
	2075/76 (#)	28916	30007	25455	32672	27325	32255	26381	18857	221868
	2075/76 (%)	96	96	93	150	95	106	100	90	102

Source: HMIS/MD/DoHS

In FY 2074/75, the proportion of diarrhoeal cases treated with ORS and Zinc as per CB-IMNCI clinical protocol at Provincial level was 102%. This must be because of reporting error, because Mahottari district alone has reported that 150% of diarrhoeal cases in the district were treated with ORS and Zinc.

Acute Respiratory Infections

ARI management is one of the major components of CB-IMNCI program. As per CB-IMNCI protocol, every ARI cases should be correctly assessed and classified as no pneumonia, pneumonia or severe pneumonia; and given home therapy, treated with appropriate antibiotics or referred to higher centre as per the indications.

Table 14: Acute respiratory infection (ARI) and pneumonia cases by districts

Indicators	***FY***	***Saptari***	***Siraha***	***Dhanusha***	***Mahottari***	***Sarlahi***	***Rautahat***	***Bara***	***Parsa***	***Province No. 2***
Target pop. (<5 years that are prone to ARI)	2073/74	70675	70083	83738	70133	87703	81102	80276	69651	613361
	2074/75	71052	70386	84221	70626	88634	82447	81438	70580	619384
	2075/76	71328	70590	84582	71026	89439	83701	82514	71415	624595
Total ARI cases	2073/74	35119	43459	40572	32865	22125	33401	31247	26171	264959
	2074/75	29786	39135	31652	31409	24878	29607	22168	18997	227632
	2075/76	41363	45502	41935	35700	42443	32574	31292	22321	293130
ARI incidence per 1,000 <5 year population	2073/74	512.7	696.7	522.5	514.2	277.3	458.9	421.7	416.5	471.6
	2074/75	509.7	658.6	443.5	499.9	332	405.7	415.7	321.2	443.4
	2075/76	586.6	693.1	555	516	513.6	423.7	390.3	326.8	498.4
Total Pneumonia cases (HF+ORC)	2073/74	2094	5383	4227	4626	2253	6246	3012	3620	31461
	2074/75	1783	4533	3445	3632	2671	4410	1911	2138	24523
	2075/76	1462	3535	3336	3240	3978	3974	1664	1732	22921
Incidence of pneumonia per 1,000 <5 children	2073/74	30.6	78	51.3	67.2	26.1	80	39.2	54.2	90.6
	2074/75	25.6	65.1	42	52.6	31.6	55.3	24.5	31.9	66.1
	2075/76	21.3	51.3	40.5	47.5	46.4	51.6	20.9	26	65.3
% of pneumonia among ARI cases	2073/74	6.0	12.4	10.4	14.1	10.2	18.7	9.6	13.8	11.9
	2074/75	6.0	11.6	10.9	11.6	10.7	14.9	8.6	11.3	10.8
	2075/76	3.5	7.8	8.0	9.1	9.4	12.2	5.3	7.8	7.8
% of severe pneumonia among ARI cases	2073/74	0.114	0.161	0.155	0.183	0.041	0.524	0.365	0.447	0.245
	2074/75	0.111	0.128	0.281	0.264	0.523	0.503	0.392	0.605	0.323
	2075/76	0.133	0.167	0.160	0.314	0.226	0.737	0.163	0.345	0.264
Deaths due to ARI at HF	2073/74	0	0	0	1	0	3	5	8	17
	2074/75	0	1	0	0	5	0	0	0	6
	2075/76	4	2	0	9	6	0	3	0	24
	2073/74	0.000	0.322	0.000	0.000	0.362	0.000	0.032	0.000	0.087

ARI Case fatality rate per 1000 at HF	2074/75	0	0.026	0	0	0.201	0	0	0	0.026
	2075/76	0.24	0.10	0.00	0.62	0.37	0.00	0.25	0.00	0.2

Source: HMIS/MD/DoHS

In FY 2075/76, a total of 293,130 ARI cases were identified which is significantly more than last FY (227,632). This has also been reflected by the increase of ARI incidence from 443 per thousands under-five population in FY 2074/75 to 498 per thousands in FY 2075/76. The incidence of pneumonia (both pneumonia and severe pneumonia at HF and PHC/ORC) however has shown decreasing trend at provincial level which has reduced from 91 percent in FY 2073/74 to 65 percent in FY 2075/76. Similarly, Rautahat has consistently shown highest pneumonia incidence rate in the past three years out of alls 8 districts of Province 2. Percent of pneumonia cases and severe pneumonia cases among ARI cases have shown decreasing trends in the last 3 FYs, indicating that most of the ARI cases must be no pneumonia cases.

The total ARI-related deaths at health facilities were reported to be 24 in the FY 2075/76 which is higher than 6 in FY 2074/75. The ARI case fatality rate was 0.2 per thousand at health facility at Provincial level. Three of the districts however had reported 0 deaths (Dhanusha, Rautahat and Parsa).

Other common childhood illnesses

CB-IMNCI Program also focuses on identifying and treating Malaria, Malnutrition, Measles, and other common illnesses among children under five years of age. The interventions to address malnutrition among children are being led by nutrition section under Family Welfare Division and interventions to address measles and other vaccine preventable diseases are being led by Immunization and CB-IMNCI Section, and Malaria is led by EDCD. Immunization and IMNCI Section (FWD) collaborates with Nutrition Section and with EDCD for the reduction of Malnutrition and Measles and other common childhood diseases in an integrated approach to childhood diseases.

Table 15: Classification of cases as per CB-IMNCI protocol by districts

Institutions	*Year*	*Malaria*		*Very severe febrile disease*	*Measles*	*Ear infection*	*Severe malnutrition*	*Anaemia*
		Falciparum	**Non-falciparum**					
Saptari	2073/74	0	0	0	0	0	0	0
	2074/75	0	1	0	0	0	0	0
	2075/76	0	0	0	0	0	0	0
Siraha	2073/74	0	0	0	0	0	0	0
	2074/75	5	7	0	0	0	0	0
	2075/76	0	5	0	0	0	0	0
Dhanusha	2073/74	0	0	0	0	0	0	0
	2074/75	14	8	0	0	0	0	0
	2075/76	11	6	0	0	0	0	0
Mahottari	2073/74	0	0	0	0	0	0	0
	2074/75	0	15	0	0	0	0	0
	2075/76	8	61	0	0	0	0	0
Sarlahi	2073/74	0	2	0	0	0	0	0
	2074/75	15	92	0	0	0	0	0
	2075/76	6	154	0	0	0	0	0
Rautahat	2073/74	0	0	0	0	0	0	0
	2074/75	0	3	0	0	0	0	0
	2075/76	1	23	0	0	0	0	0
Bara	2073/74	0	0	0	0	0	0	0
	2074/75	18	12	0	0	0	0	0
	2075/76	22	80	0	0	0	0	0
Parsa	2073/74	0	0	0	0	0	0	0
	2074/75	0	2	0	0	0	0	0

	2075/76	1	3	0	0	0	0	0
Province No. 2	2073/74	0	2	0	0	0	0	0
	2074/75	52	140	0	0	0	0	0
	2075/76	49	332	0	0	0	0	0

Source: HMIS/MD/DoHS

Under the CB-IMNCI programme, health workers identified 49 Falciparum malaria cases, 332 non-falciparum malaria cases and 0 measles cases, ear infection cases, severe malnutrition cases and anaemia cases in children under five years of age at Provincial level in FY 2075/76. There were no reported cases of very severe febrile disease in this FY. All these HMIS data must be carefully analyzed, because it is a well known fact that being Terai region many children suffer from fever, also there were some measles outbreaks last year which have clearly not been reported. Also, NDHS 2016 has shown that Province 2 as having highest childhood malnutrition with 37% stunting, 14% wasting, 37% Underweight and 59% anaemia. CB-IMNCI protocol mandates that all sick children visiting HFs need to be assessed for malnutrition and treated accordingly, but if malnutrition cases are not being reported, it surely depicts that CB-IMNCI program requires serious bolstering.

All the HMIS data regarding treatment of childhood illnesses must be carefully interpreted because the data shows widespread discrepancies, to the point that it does not make any senses (more than 100% cases identified in the health facilities receiving treatments; zero reporting or cases identified in most unlikely of the indicators). Also the data should be carefully interpreted because as per NDHS 2016, 62.4% of the sick children seek care from private medical sector for ARI and 50% for diarrhoea, and government sector caters services to just 22.8% for ARI and 15.7% for diarrhoea; and it is a well-known fact that the HMIS has not been able to encompass the reporting from private sector so far.

2.3.4 Problems, constraints and actions

Problems/Constraints	Action to be taken	Responsibility
Widespread discrepancies in data has reduced the reliability of HMIS reported data, especially in CB-IMNCI program, of indicators such as treatment of pneumonia with antibiotics; treatment of diarrhoea with ORS and Zn	• Improve quality of HMIS data by discussion of data quality in monthly review meetings at all levels, such as HF level and local level • Quality Onsite coaching , mentoring and monitoring	Local level, Health workers

2.4 Safe Motherhood

Background:
The goal of the National Safe Motherhood Programme is to reduce maternal and neonatal morbidity and mortality and improve maternal and neonatal health through preventive and promotiv activities and by addressing avoidable factors that cause death during pregnancy, childbirth and the postpartum period. Evidence suggests that three delays are important factors for maternal and newborn morbidity and mortality in Nepal (delays in seeking care, reaching care and receiving care.

The following major strategies have been adopted to reduce risks during pregnancy and childbirth and address factors associated with mortality and morbidity:

- Promoting birth preparedness and complication readiness including awareness raising and improving preparedness for funds, transport and blood transfusion.
- Expansion of 24 hours birthing facilities alongside Aama Suraksha Programme promotes antenatal check-ups and institutional delivery.
- The expansion of 24-hour emergency obstetric care services (basic and comprehensive) at selected health facilities in all districts.

The Safe Motherhood Programme, initiated in 1997 has made significant progress with formulation of safe motherhood policy in 1998. Service coverage has grown along with the development of policies, programmes and protocols. The policy on skilled birth attendants (2006) highlights the importance of skilled birth attendance (SBA) at all births and embodies the government's commitment to train and deploy doctors, nurses and ANMs with the required skills across the country. Introduction of Aama programme to ensure free service and encourage women for institutional delivery has improved access to institutional deliveries and emergency obstetric care services. The Nepal Health Sector Strategy (NHSS) identifies equity and quality of care gaps as areas of concern for achieving the maternal health sustainable development goal (SDG) target, and gives guidance for improving quality of care, equitable distribution of health services and utilisation and universal health coverage with better financing mechanism to reduce financial hardship and out of pocket expenditure
for ill health.

Main strategies of the Safe Motherhood Programme

1. Promoting inter-sectoral coordination and collaboration at Federal, Provincial, districts and Local levels to ensure commitment and action for promoting safe motherhood with a focus on poor and excluded groups.
2. Strengthening and expanding delivery by skilled birth attendants and providing basic and Comprehensive obstetric care services at all levels. Interventions include:
    - developing the infrastructure for delivery and emergency obstetric care;
    - standardizing basic maternity care and emergency obstetric care at appropriate levels of the health care system;
    - strengthening human resource management —training and deployment of advanced skilled birth attendant (ASBA), SBA, anaesthesia assistant and contracting short-term human resources for expansion of services sites;

- establishing a functional referral system with airlifting for emergency referrals from remote areas, the provision of stretchers in Palika wards and emergency referral funds in all remote districts; and

3. Strengthening community-based awareness on birth preparedness and complication readiness through FCHVs and increasing access to maternal health information and services.
4. Supporting activities that raise the status of women in society.
5. Promoting research on safe motherhood to contribute to improved planning, higher quality services and more cost-effective interventions.

Major activities in 2075/76

- Community level maternal and newborn health interventions
- Reproductive health morbidity prevention and management programme
- Expansion and quality improvement of service delivery sites
- Onsite clinical coaching and mentoring
- MNH readiness Hospital and BC/BEONC Quality Improvement
- Emergency referral funds
- Safe abortion services
- Obstetric first aid orientations
- NyanoJhola Programme
- Aama and Free Newborn Programme

Provisions of the Aama Programme and Newborn Programme

Aama programme provision

a. For women delivering their babies in health institutions:
Transport incentive for institutional delivery: Cash payment to women immediately after institutional delivery (NPR 3,000 in mountains, NPR 2,000 in hills and NPR 1000 in Tarai districts).

Incentive for 4 ANC visits: A cash payment of NPR 800 to women on completion of four ANC visits at 4, 6, 8 and 9 months of pregnancy, institutional delivery and postnatal care.

Free institutional delivery services: A payment to health facilities for providing free delivery care. For a normal delivery health facilities with less than 25 beds receive NPR 1,000 and health facilities with 25 or more beds receive NPR 1,500. For complicated deliveries health facilities receive NPR 3,000 and for C- sections (surgery) NPR 7,000. Ten types of complications (antepartum haemorrhage (APH) requiring blood transfusion, postpartum haemorrhage (PPH) requiring blood transfusion or manual removal of placenta (MRP) or exploration, severe pre-eclampsia, eclampsia, MRP for retained placenta, puerperal sepsis, instrumental delivery, and management of abortion complications requiring blood transfusion) and admission longer than 24 hours with IV antibiotics for sepsis are included as complicated deliveries. Anti-D administration for RH negative is reimbursed NPR 5,000. Laparotomies for perforation due to abortion, elective or emergency C-sections, laparotomy for ectopic pregnancies and ruptured uterus are reimbursed NPR 7,000 to both public and private facilities.

b. Incentives to health service provider:
For deliveries: A payment of NPR 300 to health workers for attending all types of deliveries ***to be arranged from health facility reimbursement amounts***.

Newborn Care Programme Provision

a. For sick newborns:
There are four different types of package (Package 0, Package A, B, and Package C) for sick newborns case management. Sick newborn care management cost is reimbursed to health facility. The cost of package of care include 0 Cost for Packages 0, and NPR 1000, NRP 2000 and NRP 5000 for package A, B and C respectively. Health facilities can claim a maximum of NPR 8,000 (packages A+B+C), depending on medicines, diagnostic and treatment services provided.

b. Incentives to health service provider:
A payment of NPR 300 to health workers for providing all forms of packaged services ***to be arranged from health facility reimbursement amounts***.

Achievements

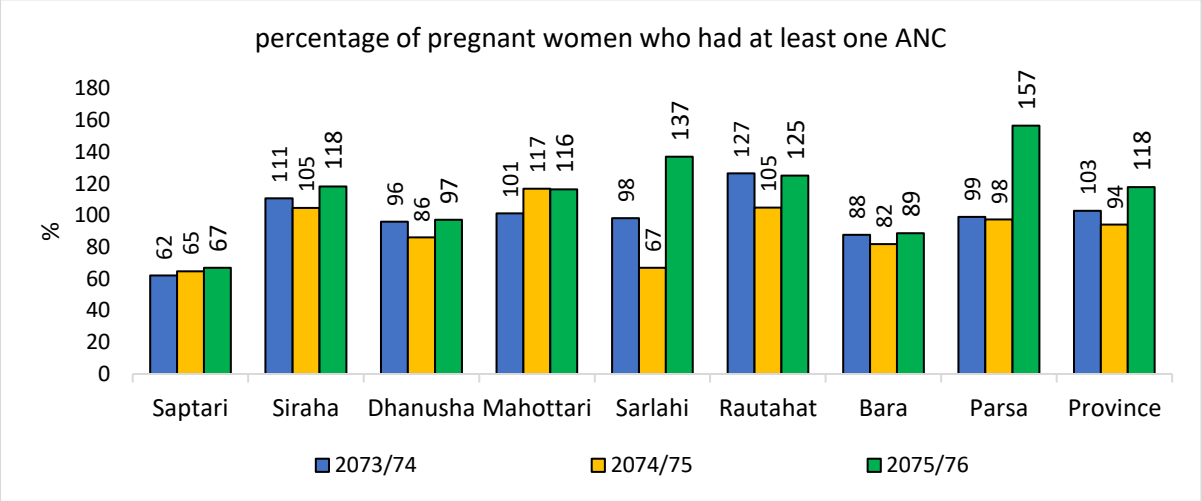
Antenatal care

WHO recommends a minimum of four antenatal check-ups at regular intervals to all pregnant women (at the fourth, sixth, eighth and ninth months of pregnancy). During these visits women should receive the following services and general health check-ups:

- Blood pressure, weight and foetal heart rate monitoring.
- IEC and BCC on pregnancy, childbirth and early newborn care and family planning.
- Information on danger signs during pregnancy, childbirth and in the postpartum period, and timely referral to appropriate health facilities.
- Early detection and management of complications during pregnancy.
- Provision of tetanus toxoid and diphtheria (Td) immunization, iron folic acid tablets and deworming tablets to all pregnant women, and malaria prophylaxis where necessary.

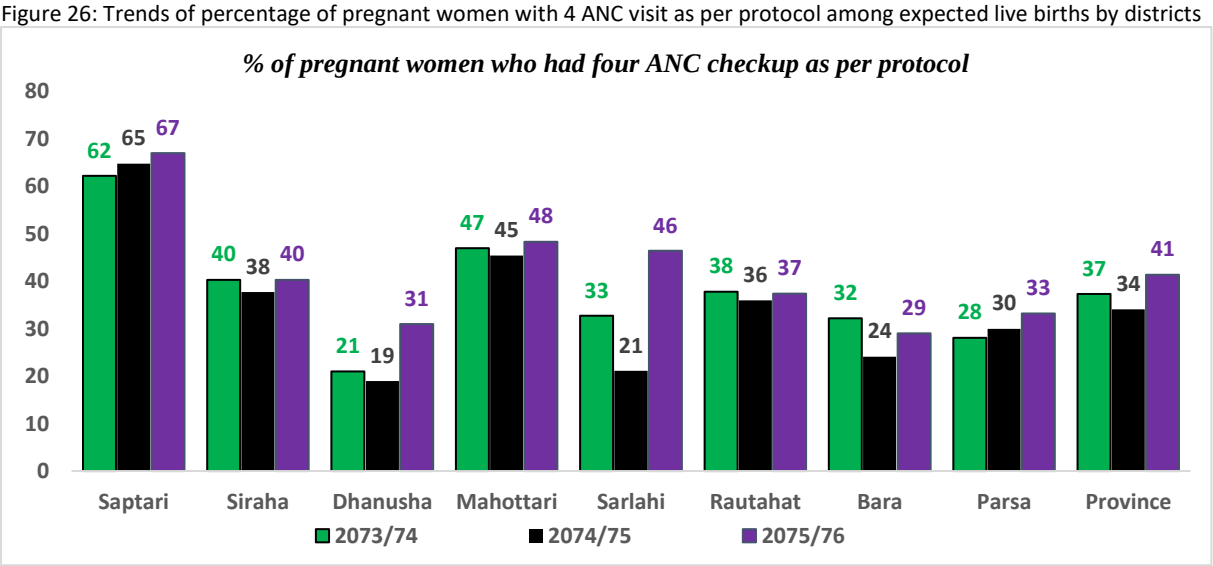
Antenatal care visits are provided free of cost to all women visiting public health facilities and women are encouraged to visit health facilities for ANC at least four times during pregnancy, give birth in health facilities in support from skilled health workers and receive three post-natal care in health facilities. The provincial average for ANC visit at any time has increased from 94 percent in 2074/75 to 118 percent in 2075/76. In comparison to last fiscal year, higher percent of women made at least one ANC visit during 2075/76 in all districts except Mahottari. Highest increment was observed in Sarlahi and Parsa district. As the indicator is measured against expected live birth, the achievement was more than 100%. The trend of ANC visit at least one time by women is given in Figure 25.

Figure 25: Provincial and district trend of women visited for ANC at least one time



Pregnant women visiting health facilities for ANC checkup according to protocol has increased in FY 2075/76 in comparison to last FY in all districts marking 20% increase at province level. Highest percentage increase in four ANC visit of 119% (21 % vs46%) as per protocol was observed in Sarlahi district. Among all the districts, highest percentage of women visited for 4 ANC was observed in Saptari district and lowest was observed in Bara district. Out of total districts, only 3 (Saptari, Mohattari and Sarlahi) has achieved higher percentage of pregnant women having 4 ANC visit as per protocol than provincial average. Despite increment achieved in four ANC visit, provincial progress is still lacking behind national average (in FY 2075/76). Again, there is huge gap (118 vs 41) between percentage of pregnant women visiting health facilities for ANC at any time and four ANC visit as per protocol. This may have observed due to inadequate counselling to pregnant women about the importance of regular ANC checkups. The trend of 4ANC visit according to protocol is given Figure 26.

Figure 26: Trends of percentage of pregnant women with 4 ANC visit as per protocol among expected live births by districts



Global evidences suggest that maternal anaemia during pregnancy increases the risk of prematurity and low birth weight. Thus, iron folic acid is provided to every pregnant woman those visiting health facilities during pregnancy.

Percentage of women receiving 180 tablet of iron folic acid increased from 46% in FY 2074/75 to 57% in FY 2075/76 achieving nearly 24 percent point increase at province level. As compared to FY 2074/75, the percentage of pregnant women receiving iron folic acid increased in all districts except Saptari and Mahottari in FY 2075/76. Percentage of postpartum mother receiving iron folic acid for 45 days remained stagnant for previous two fiscal years, but in fiscal year 2075/76 it reached to 44 percent from 40 percent in comparison to FY 2074/75. Percentage of postpartum mother who received iron folic acid tablet decreased in four districts (50% of districts) while it increased in rest four districts while compared to previous fiscal year.

Figure 27: Three years' trend in percentage of pregnant women who received 180 iron tablet during pregnancy

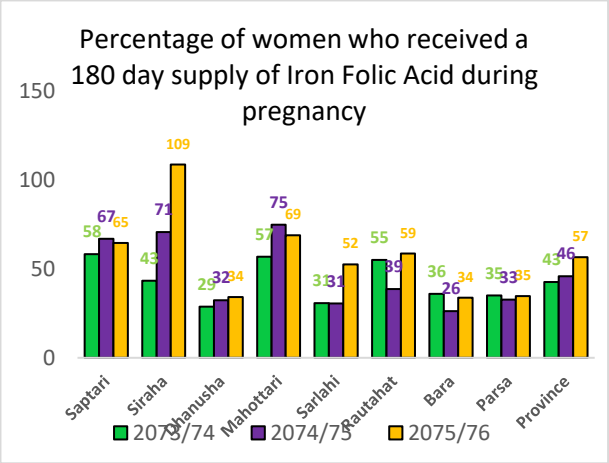


Table 16: Percentage of postpartum mother received iron folic acid tables for 45 days

District	2073/74	2074/75	2075/76
Saptari	47	47	43
Siraha	47	45	54
Dhanusha	35	36	33
Mahottari	47	46	43
Sarlahi	28	38	57
Rautahat	46	39	48
Bara	35	37	36
Parsa	37	34	35
Province	40	40	44

Delivery care

Delivery care services include:

- skilled birth attendance at home and facility-based deliveries;
- early detection of complicated cases and management or referral (after providing obstetric first aid) to an appropriate health facility where 24 hours emergency obstetric services are available; and
- the registration of births and maternal and neonatal deaths.

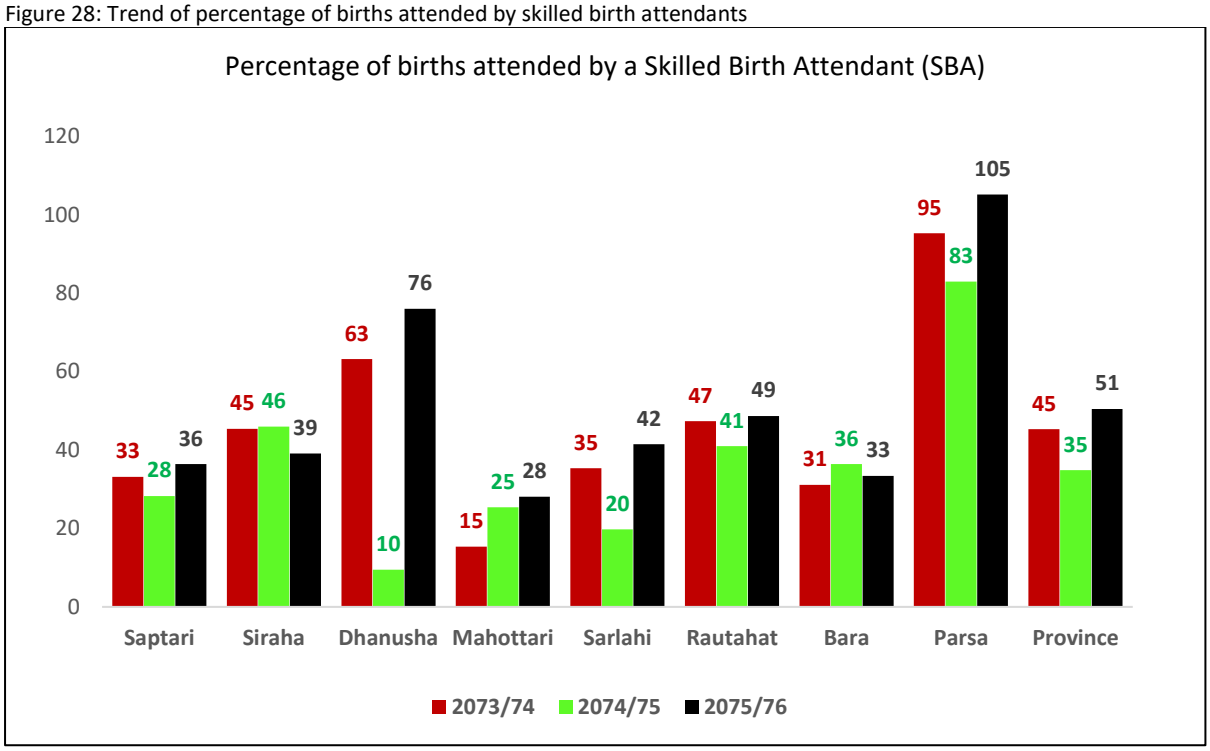
Although women are encouraged to deliver at a facility, home delivery ensuring clean delivery kits with provision of misoprostol to prevent post-partum haemorrhage and early identification danger signs and complications, are important components of delivery care in settings where institutional delivery services are not available or not used by the women.

Delivery attended by Skilled Birth Attendants (SBA)

Nepal is committed to achieving 90 percent of all deliveries attended by SBAs in health facilities to achieve the targets of sustainable development goals by 2030. At provincial level, as compared to FY 2074/75 percentage of women attended by skilled birth attendants increased form 35 percent to 51 percent in 2075/76. Percentage of deliveries attended by SBA increased in six districts whereas it decreased in Siraha and Bara district. Highest percentage of deliveries attended by SBA was achieved by Parsa district (105%) whereas highest percentage point increase was made by Dhanusha district in

FY 2075/76 as compared to previous fiscal year, however the trend seems very much fluctuating in Dhanusha district.

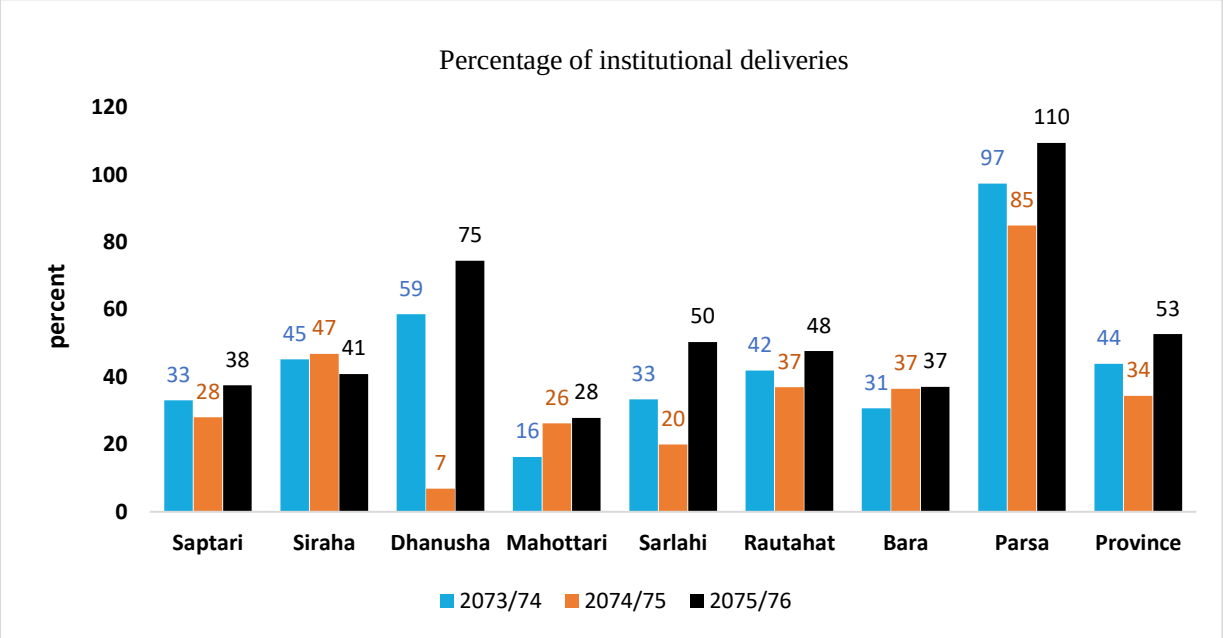
Figure 28: Trend of percentage of births attended by skilled birth attendants



Institutional delivery

At province level, 53 percent of deliveries among expected live birth were conducted health facilities in FY 2075/76, whereas it was only 34 percent in FY 2074/75. As compared to FY 2074/75, percentage of institutional delivers increased in all the districts expect in Siraha. Dhanusha and Parss district have higher percentage of institutional delivery whereas remaining six districts have lower percentage of institutional delivery in comparison with provincial average (53%). Similar to percentage of SBA delivery, highest percentage point was achieved by Dhanusha district in FY 2075/76 in comparison to previous FY and highest number of institutional deliveries were conducted in Parsa district (110%) and lowest was observed at 37% in Bara district. Despite making substantial achievements in FY 2075/76, it seems to work more strategically to meet the targets of achieving 90 percent institutional delivery as committed in SDG by 2030.

Figure 29: Trend of institutional deliveries



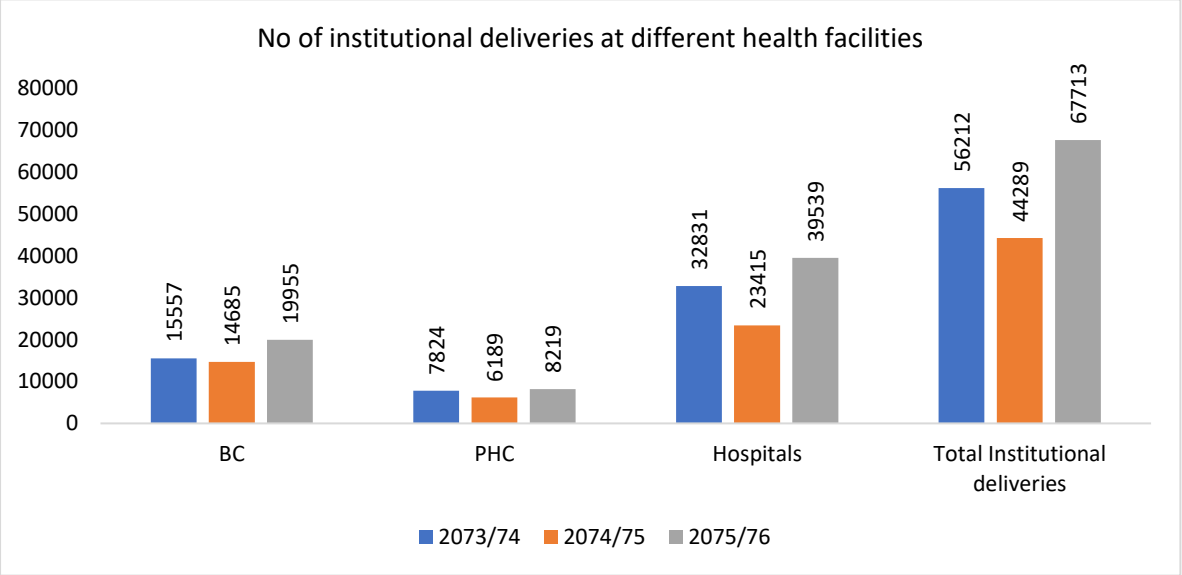
There are altogether 196 health institution providing delivery services in the province. Among the total health facilities providing delivery services, 156 (79%) are birthing centers, 31 (16%) are BEONC and rest 9 (5%) are the CEONC centers. The distribution of health facilities with birthing facilities is given as below (Table 17)

Table 17: Distribution of birthing centers, BEONC and CEONC sites by districts

District	*Number of BC*	*Number of BEONC*	*Number of CEONC*
Parsa	22	4	2
Bara	13	3	1
Rautahat	22	5	1
Sarlahi	25	5	1
Mahottari	13	7	1
Dhanusha	14	2	1
Siraha	23	2	1
Saptari	24	3	1
Total	**156**	**31**	**9**

Total number of institutional deliveries increased by 35 percentage point (67713 vs 44289) in fiscal year 2075/76 as compared to last fiscal year. The number of institutional deliveries increased in each level of health institution in FY 2075/76 in comparison to last fiscal year and highest increase was observed for hospital deliveries. This indicates that more people are visiting hospitals for delivery services. The number of institutional deliveries in different health facilities is given in the following figure (Figure 30)

Figure 30: Number of institutional deliveries in different health institutions



Among the total deliveries highest proportion of delivers were conducted in hospitals for the last three consecutives fiscal years while lowest proportion of deliveries were occurred in primary health care centers. Proportion of delivers conducted in hospitals and birthing centers increased in FY 2075/76 as compared to last fiscal year while it decreased in primary health centers. The proportion of deliveries occurred in different health facilities for the last consecutive years is given in below table.

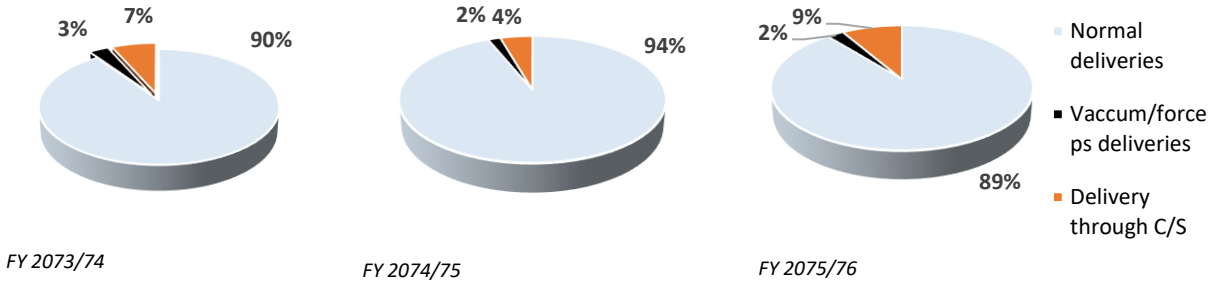
Table 18: Proportions of Institutional deliveries at different types of health institutions

FY	*BC*	*PHC*	*Hospitals*
2073/74	28	14	58
2074/75	33	14	53
2075/76	29	12	58

Emergency obstetric care:

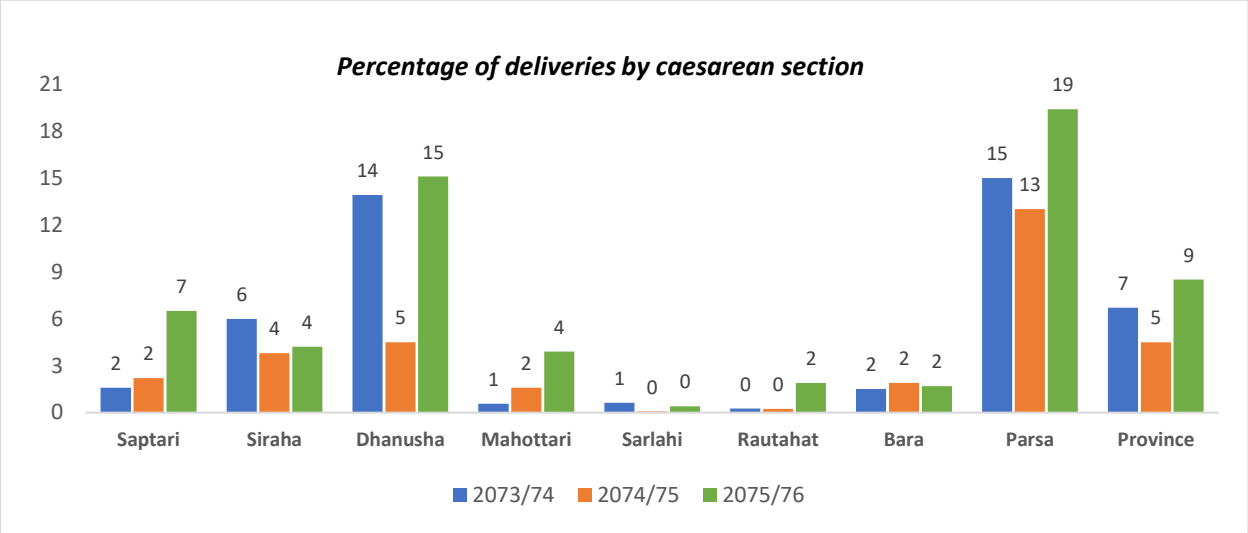
Basic emergency obstetric and newborn care (BEONC) covers the management of pregnancy complications by assisted vaginal delivery (vacuum or forceps), the manual removal of placentas, the removal of retained products of abortion (manual vacuum aspiration), and the administration of parental drugs (for postpartum hemorrhage, infection and pre-eclampsia and eclampsia) and the resuscitation of newborns and referrals. Comprehensive emergency obstetric care (CEONC) includes surgery (caesarean section), anesthesia and blood transfusions along with BEONC functions.

Figure 31: Proportion of mode of delivery for fiscal year 2073/74 to 2075/76



At province level 89 percent of institutional deliveries were conducted normally, 9 percent through caesarean section and remaining 2 percent were complicated deliveries. As compared to previous FY, the percentage of caesarean section delivery increased in all districts and highest percentage of C/S deliveries were conducted in Paras district (19%), whereas greatest percent point increase of CS deliveries was observed in Dhanusha district (5% vs 15%) in FY 2075/76. (Figure No 32)

Figure 32: Trend of proportion of deliveries by C/S among total deliveries



According to WHO standard, it is estimated that 15 percent of expected delivery suffer from major obstetric complications throughout pregnancy, childbirth or immediate during postpartum period. In comparison to last fiscal year the percentage of met need for EOC increased to 27.7% in FY 2075/76, from 20.5% in fiscal year 2074/75

Table 19: Met need for EOC services for FY 2073/74 to 2075/76

Fiscal year	*Total expected live births*	*15% of expected live births (estimated proportion needing EmOC)*	*Number of obstetric complications managed*	*Met need for EOC services (%)*
2073/74	128037	19205	3844	20
2074/75	128646	19297	3967	20.5
2075/76	128439	19265	5349	27.7

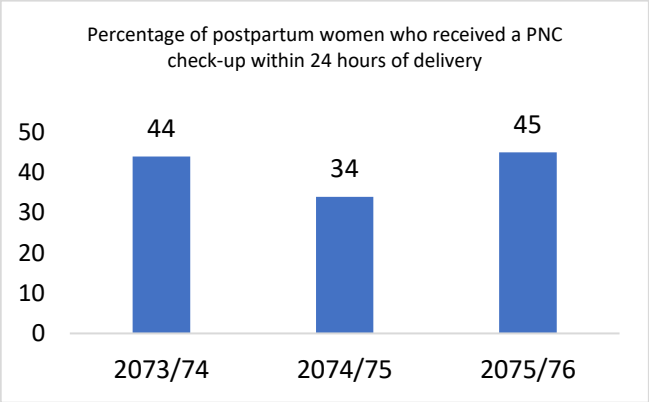
Postnatal care

Postnatal care services include the following:

- Three postnatal check-ups, the first in 24 hours of delivery, the second on the third day and the third on the seventh day after delivery.
- The identification and management of complications of mothers and newborns and referrals to appropriate health facilities.
- The promotion of exclusive breastfeeding.
- Personal hygiene and nutrition education, and postnatal vitamin A and iron supplementation for mothers.
- The immunization of newborns.

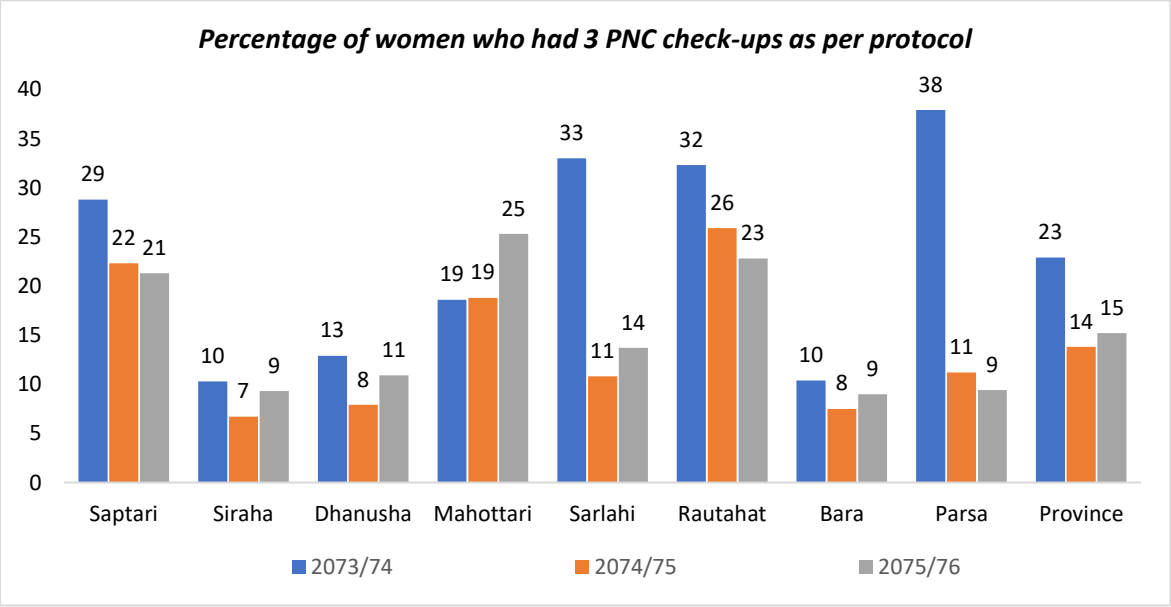
- Postnatal family planning counselling and services.

Postnatal checkup by mothers



The proportion of post-partum mothers attending three post-natal care as per protocol has increased only by 1% point in FY 2075/76 (15%) as compared to previous FY (14%) at provincial level. Three PNC visit as per protocol has declined in all districts, except Mahottari in FY 2074/75 as compared with FY 2073/74. However, PNC visit as per protocol increased in all districts in FY 2075/76 as compared with last fiscal year, expect for Saptari district. First PNC checkup within 24 hours of delivery increased to 45 percent in FY 2075/76 from 34 percent in 2074/75, but it was 44% in FY 2073/74 at province level (Figure 31). Huge gap remained while comparing first PNC check-up within 24 hours (45%) with three PNC check-up as per protocol (15%). Low utilization of post-natal care services by mothers may be due to so cultural causes and inadequate information about the importance of PNC visits. Therefore, it is needed to focus more about informing mothers about the importance of PNC checkups for health of mother and newborn baby soon after having delivery.

Figure 33: Percentage of women who had 3 PNC checkup as per protocol



Safe abortions

Safe abortion services were provided from certified service sites by trained health care providers in Nepal since FY 2060/61. In FY 2075/76, 6.2% of total pregnancies were terminated at health facilities

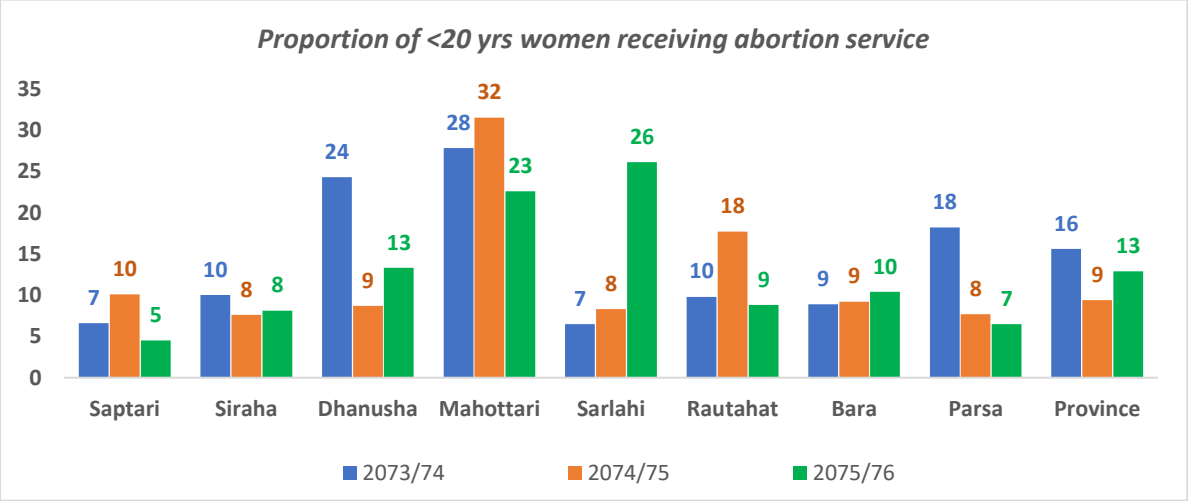
where as 4.2 percent of pregnancies were aborted in previous year either by medical or surgical procedure at province level. Highest percentage of safe abortion services were provided in Siraha (12.4%) followed by Parsa (11.8%), and Sarlahi (10.1%) in FFY 2075/76, where as highest percentage of safe abortion were provided in Parsa district is last two fiscal years. Table 20 shows the percentage of pregnancies terminated by medical and surgical procedure for three consecutive fiscal years by districts.

Table 20: Percentage of pregnancies terminated by medical and surgical procedure at health facility

District	*FY 2073/74*			*FY 2074/75*			*FY 2075/76*		
	Medical	**Surgical**	**Total**	**Medical**	**Surgical**	**Total**	**Medical**	**Surgical**	**Total**
Saptari	4.3	0.06	**4.36**	4.8	0.2	**5**	3	0.37	**3.37**
Siraha	4.9	1.6	**6.5**	7.6	3.3	**10.9**	8.5	3.9	**12.4**
Dhanusha	3	3.6	**6.6**	1.7	0	**1.7**	4.6	3.1	**7.7**
Mahottari	0.73	1.6	**2.33**	0.9	0.04	**0.94**	0.99	0	**0.99**
Sarlahi	0.42	0.8	**1.22**	0.98	0.25	**1.23**	5.5	4.6	**10.1**
Rautahat	3	0.41	**3.41**	1.8	0.1	**1.9**	2.3		**2.3**
Bara	1.8	0.11	**1.91**	1.2	0.15	**1.35**	0.55	0.05	**0.6**
Parsa	6	7	**13**	4.8	7.3	**12.1**	4.2	7.6	**11.8**
Province	2.9	1.8	**4.7**	2.9	1.3	**4.2**	3.7	2.5	**6.2**

Among the total safe abortion service users in FY 2075/76, thirteen (13) percent were women of age less than 20 years which is four (4) percent point increase in comparison to FY 2074/75 at province level. As compared with last fiscal year, the proportion of less than 20 years women receiving safe abortion services decreased in Saptari, Mahottari, Rautaht and Parsa district while it increased in remaining districts. Highest percentage of abortion service received by under 20 pregnant women was observed Sarlahi district (26%), followed by Mahottari (23%) and lowest was observed in Saptari (5%) district.

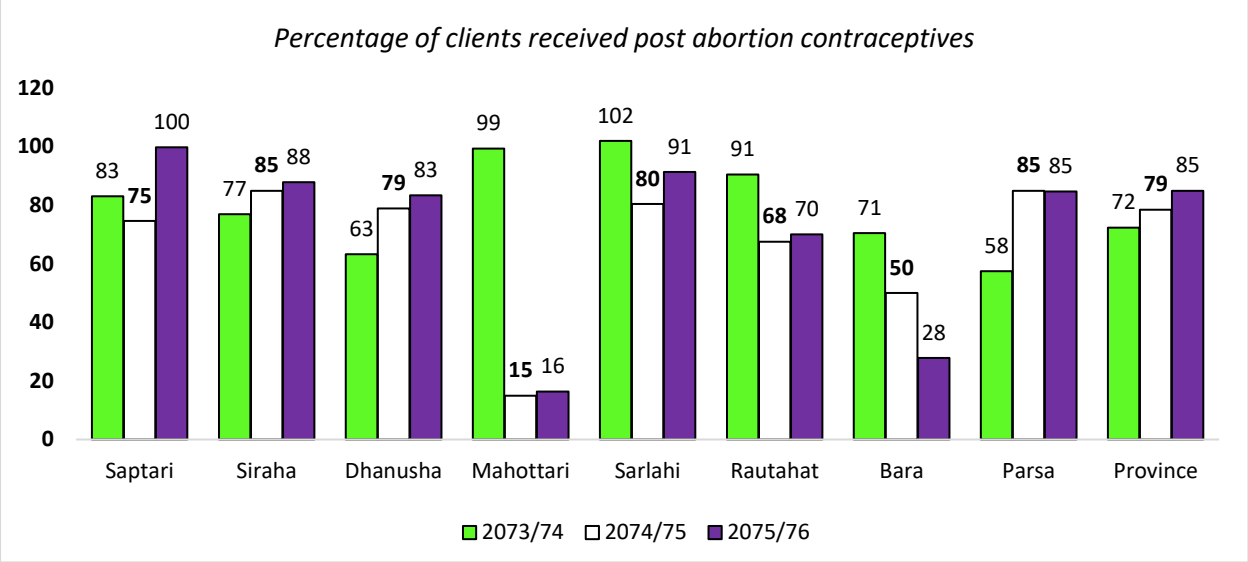
Figure 34: Trend of under 20 yrs women receiving safe abortion services



At province level, use of contraceptives by safe abortion service users is in increasing trend since last three fiscal years and it was observed at 85 percent in FY 2075/76. All the safe abortion service clients were provided with contraceptive services in Saptari district (100%) while that was only 16 percent in

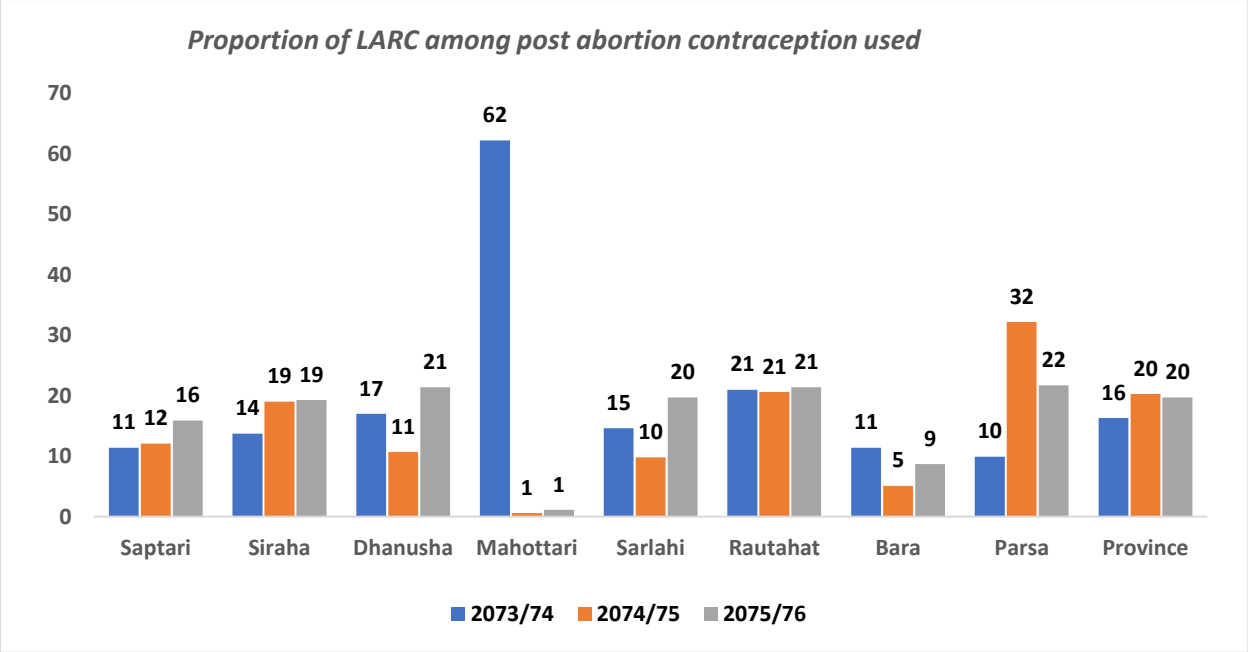
Mahottari district in FY 2075/76. In all the districts, percentage of clients receiving post abortion contraceptives increased in FY 2075/76 as compared to previous fiscal year expect in Bara district.

Figure 35: Trends of Post abortion contraceptive use



In an aggregate for province level, among the total contraceptive users after safe abortion services, less than one quarter (20%) used long acting reversible contraceptive methods in 2075/76 and remained same as of previous FY. Which clearly indicates that coverage for LARC service is nominal and it may be due to lack of trained human resources, commodities, misconception among the users and inadequate information about the services.

Figure 36: Trends of proportion of LARC use after abortion



Issues, constraints and recommendations- safe motherhood

Table 21: Issues, constraints and recommendations for Safe Motherhood program

Issues and constraints	Recommendations	Responsibilities
Functionality of CEONC and birthing centre services is not adequate	•Focusing on functionality and quality of existing CEONC sites, rather than establishing new sites •Monitoring service provision status and availability of human resource •Ensure appropriate skill mix at CEONC sites by deployment and appropriate transfer of skilled human resources •Continue allocation of fund for contracting out short – term service providers •Support local government for training of human resources in necessary skills	MoSD, PHD
Availability of quality maternity care services at hospitals and birthing centres: • 24/7 availability of services • skills and knowledge of staff • enabling environment and motivation • overcrowding at referral hospitals.	• Introduce quality improvement process for all maternity care services including QIP self-assessment and on-site clinical coaching • Introduce monitoring process indicator for quality maternity care in health facilities • Adequate budgets allocated for equipment in birthing centres and CEONC sites • Regular MNH skills update programmes for nurses focusing on continuum of care • Introduce construction standards for birthing centres • Support birthing centres at strategic locations only • Provide additional budgetary support for overcrowded hospitals	MoSD, PHD
Plateauing of 4ANC use and timely first ANC visits, and very low PNC coverage	• Raise the quality of ANC counselling services, focusing on continuum of care • Develop a special package to encourage timely first ANC visits. • Initiate PNC home visit in selected locations	MoSD, PHD,
Low use of institutional delivery	• Develop a strategy to reach unreached sub-populations • Rapidly assess and expand rural ultrasonography (USG) • Expand services in remote and difficult locations and ensure continuous availability of services (birthing centres and CEONC services)	MoSD, PHD
The inadequate use of some birthing centres and increasing the number of birthing	• The strategic upgrading of health facilities into birthing centres • Upgrade strategically located birthing centres to provide comprehensive quality primary health care services and aim for 'home delivery free' VDCs	MoSD, PHD, palikas

centres, and increasing use of referral hospitals	• Run innovative programmes to encourage delivery at birthing centres	
High demand for free surgery for uterine prolapse cases	• Increase the budget and ensure hospitals provides regular services of POP surgery	MoSD
Federal structure and governance of health institutions; limited understanding of health service delivery	• Orientation of local and provincial level government on their roles in health services delivery and governance	MoSD,PHD

2.5 Family Planning and Reproductive Health

Background

Family planning (FP) refers to a conscious effort by a couple to limit or space the number of children through the use of contraceptive methods. Modern methods include female sterilization (e.g. minilap), male sterilization (e.g. no-scalpel vasectomy), intrauterine contraceptive device (IUCD), implants (e.g. Jadelle), injectables (e.g. Depo Provera), the pill (combined oral pills), condoms (male condom), lactation amenorrhea method (LAM) and standard days method (SDM).

The main aim of the National Family Planning Programme is to ensure that individuals and couples can fulfil their reproductive needs by using appropriate FP methods voluntarily based on informed choices. To achieve this, the Government of Nepal (GoN) is committed to equitable and right based access to voluntary, quality FP services based on informed choice for all individuals and couples, including adolescents and youth, those living in rural areas, migrants and other vulnerable or marginalized groups ensuring no one is left behind.

GoN also commits to strengthen policies and strategies related FP within the new federal context, mobilize resources, improve enabling environment to engage effectively with external development partners and supporting partners, promote public-private partnerships, and involve non-health sectors. National and international commitments will be respected and implemented (such as NHSSIP 2015- 2020, Costed Implementation Plan 2015-2020 and FP2020 etc.).

From program perspective, GoN through its subsidiary (FWD, PHD, Health section MoSD, and municipalities) will ensure access to and utilization of quality FP services through improved contraceptive use especially among hard to reach, marginalised, disadvantaged and vulnerable groups and areas, broaden the access to range of modern contraceptives method mix including long acting reversible contraceptives such as IUCD and implant from service delivery points, reduce contraceptive discontinuation, scale up successful innovative evidence informed FP service delivery and demand generation interventions.

In Nepal, FP information, education and services are provided through the government, social marketing, NGOs and the private sector (including commercial sectors). In the government health system, short acting reversible contraceptive methods (SARCs: male condoms, oral pills and injectables) are provided through PHCCs, health posts and PHC-ORCs. FCHVs provide information and education to community people, and distribute male condoms and resupply oral contraceptive pills. Long acting reversible contraceptive (LARC) services such as intrauterine contraceptive devices (IUCDs) and implants are only available in hospitals, PHCCs and health posts that have trained and skilled providers. Access to LARC services is provided in remote areas through satellite clinics, extended visiting service providers and mobile camps. Male and female sterilization services (e.g. voluntary surgical contraception [VSC]) are provided at static sites or through scheduled seasonal and mobile outreach services. Quality FP services are also provided through private and commercial outlets such as NGO run clinic/ centre, private clinics, pharmacies, drug stores, hospitals including academic hospitals. FP services and commodities are made available by some social marketing (and limited social franchising) agencies. FP services are part of essential health care services and are provided free in all public sector outlets.

Objectives, policies and strategies

The overall objective of Nepal's FP programme is to improve the health status of all people through informed choice on accessing and using voluntary FP. The specific objectives are as follows:

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

The five policies and strategic areas to achieve the above objectives are presented as below;
Policies and strategic areas for FP

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

Target of Family Planning

Selected FP goals and indicators to ensure universal access to sexual and reproductive health-care services, including for FP/SRH programmes are as follows:

Table 22: SDG targets for family planning program

Target and Indicators	*2015*	*2019*	*2022*	*2025*	*2030*
Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods	66	71	74 7	76	80
Contraceptive prevalence rate (CPR) (modern methods - %)	47	52	53	56	60
Total Fertility Rate (TFR) (births per women aged 15-49 years)	2.3	2.1	2.1	2.1	2.1
Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group	71	56	51	43	30

Major activities in 2075/76

Following activities were implemented in FY 2075/76

- Provision of regular comprehensive FP service
- Provision of long acting reversible services (LARCs)
- FP strengthening program through the use of decision making tool (DMT) and WHO medical eligibility for contraceptive (MEC) wheel

- Micro planning for addressing unmet need of FP in low modern CPR district
- Permanent FP Methods or Voluntary Surgical Contraception (VSC)
- Development of institutionalized family planning service center as a training center
- Satellite clinic services for long acting reversible contraceptives
- Capacity building for adolescent, establishment of adolescent friendly service sites
- Basic IUCD and implant training for nursing staffs
- COFP counselling training for health workers
- Review of adolescent health program

Achievements

Current users of family planning methods in FY 2075/76

There were altogether 589667 current users for all methods (temporary and permanent) among which 469827 current users were of permanent method users and rest were temporary method. The details of current users of different methods in all the districts is given as below in the Table.23.

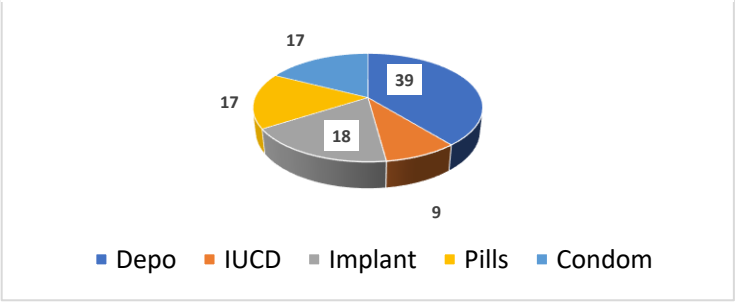
Table 23: Number of current users by methods and districts in FY 2075/76

Districts	*Depo*	*IUCD*	*Implant*	*Pills*	*Condom*	*Permanent method*	
						Female	**Male**
SAPTARI	10147	2283	1531	5323	2600	53660	467
SIRAHA	8260	1465	3080	2701	2492	52317	907
DHANUSA	5429	871	1116	3015	2678	71542	1281
MAHOTTARI	4681	726	1050	1860	2395	47038	416
SARLAHI	5301	1798	5406	2566	2773	64401	2081
RAUTAHAT	3984	674	3352	1848	2797	54003	589
BARA	5027	1262	2952	1486	3077	38253	1575
PARSA	4044	1411	3112	1185	2081	78727	2570
Province	**46873**	**10490**	**21599**	**19984**	**20894**	**459943**	**9884**

Proportion of current users among the temporary method users

In the fiscal year 2075/76; among the total current users of five temporary methods, depo occupied the greatest part (39%) of contraceptive method mix followed by implant (18%) where as IUCD occupied the lowest proportion (9%) among the current users. The proportion of current users for pills and condom were equal (17%) each.

Figure 37: Proportion of current users (temp. methods)

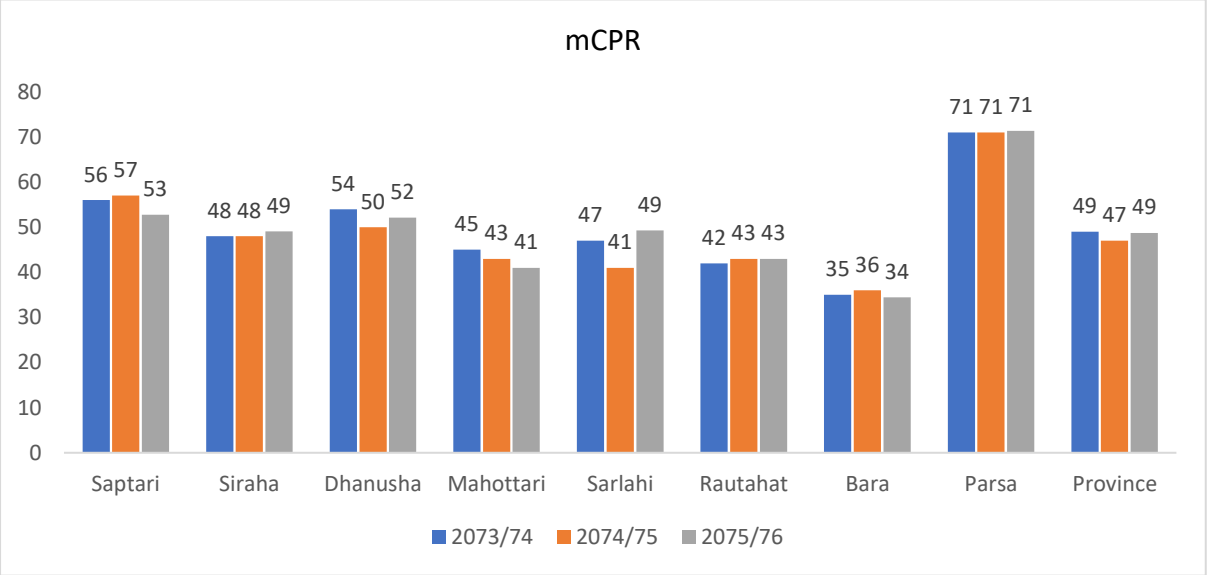


Contraceptive prevalence rate

At province level contraceptive prevalence rate for modern methods (mCPR) increased to 49% in fiscal year 2075/76 from 47% in last fiscal year 2074/75. Among the eight districts contraceptive prevalence rate for modern contraceptives increased in Siraha, Dhanusha, Sarlahi whereas it

decreased in Saptari, Mahottari and Bara district while it remained equal in Paras and Rautaht district in fiscal year 2075/76 in comparison to last fiscal year. The details of mCPR for three consecutive years for all districts of province two is given as following.

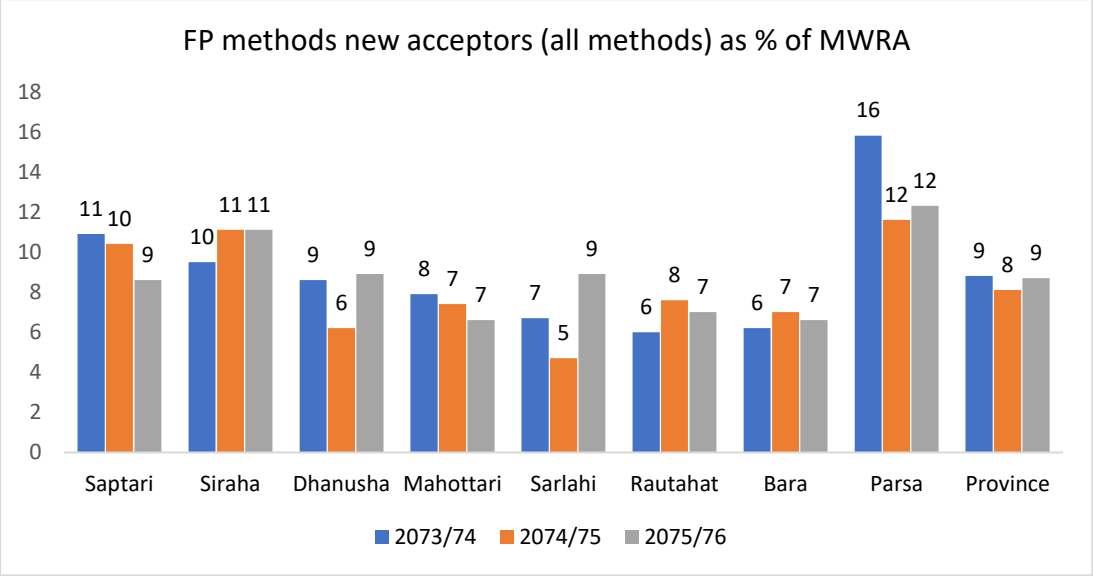
Figure 38: Trend of mCPR by districts for FY 2073/74 to 2075/76



New users as percentage of MWRA

At province level new acceptors for all methods of contraceptives as percentage of married women of reproductive age increased by one percentage point in fiscal year 2075/76 as compared to last fiscal year. Highest percentage of new acceptors for contraceptive increased in Sarlahi district in fiscal year 2075/76 as compared to last fiscal year 2074/75 (9% vs 5%), followed by Dhanusha district. Details of new acceptors as percentage of MWRA for all the districts is given in below figure (Figure 40)

Figure 39: New acceptors (all methods) as percentage of MWRA

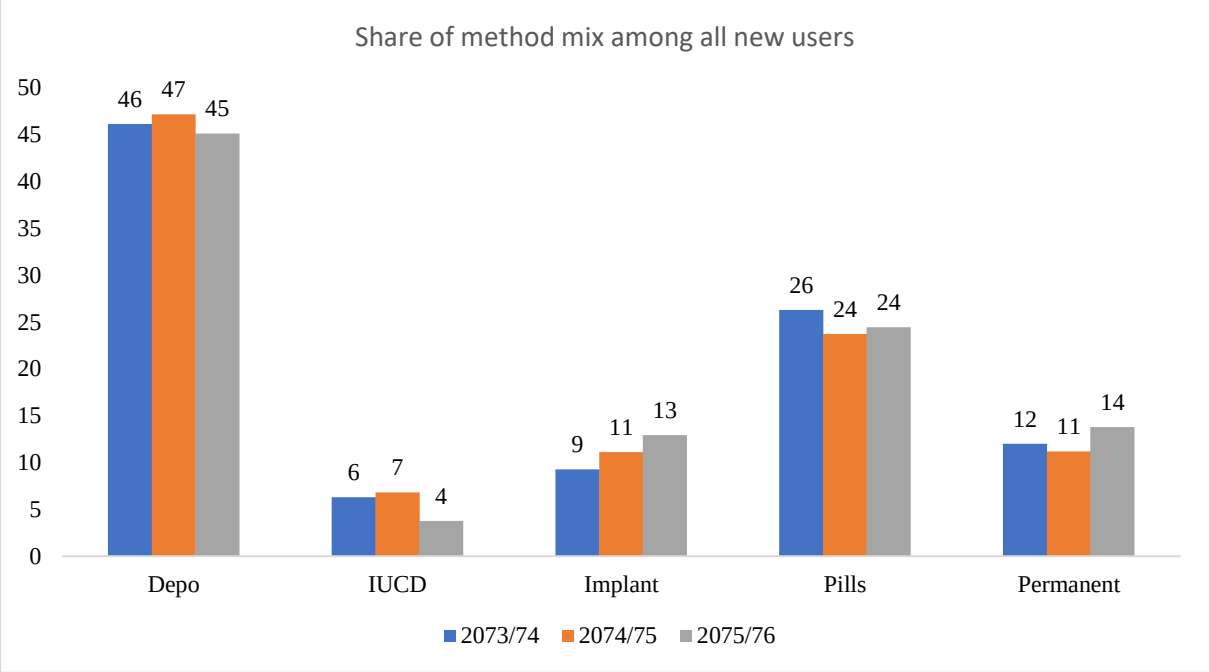


Share of FP method mix among all new acceptor

Among all the new users of family planning method highest proportion was observed for depo for the three consecutive fiscal years followed by pills. The share of implant among the total new users was

increased for implant and permanent methods in fiscal year 2075/76 as compared with last fiscal year, whereas it decreased for depo and IUCD for the same duration of time. While the share of pills users remained same within two fiscal years among the total new users of family planning methods. This indicates that more new users are attracted towards implant followed by permanent methods.

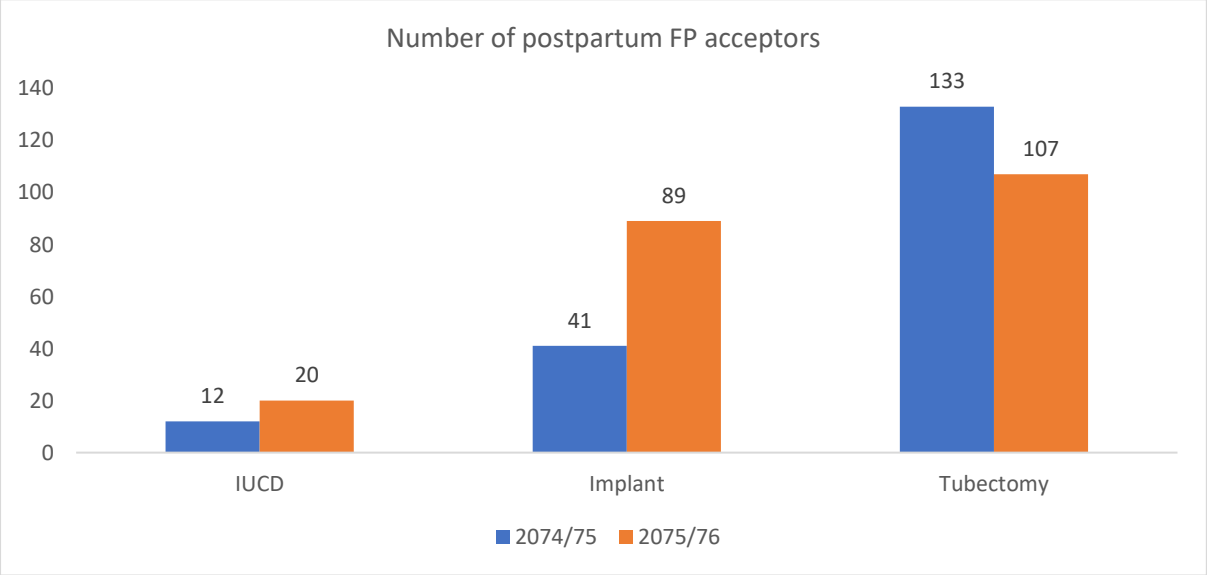
Figure 40: Proportion of family planning method mix among new users



Uptake of post-partum family planning methods within 48 hours of delivery

As compared to last fiscal year, number of women using long acting reversible contraceptives increased in fiscal year 2075/76, but the number of tubectomy decreased for the same period. Number of women using implant as post-partum family planning method increased more than double in fiscal year 2075/76 (89) in comparison to last fiscal year (41).

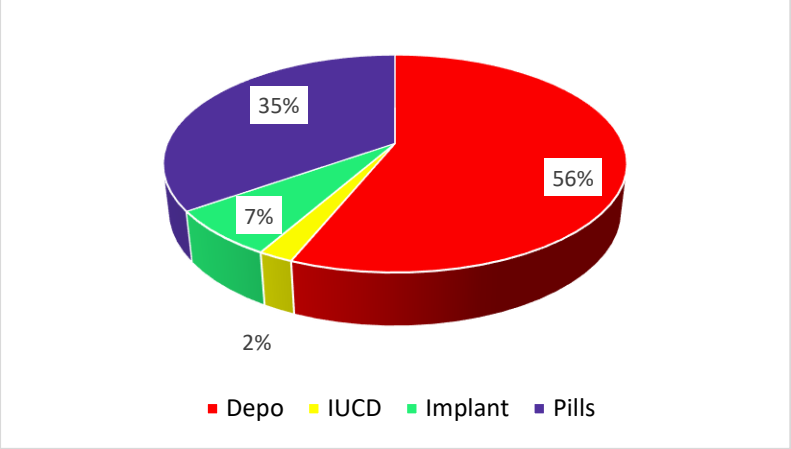
Figure 41: Postpartum FP acceptors (within in 48 hours of delivery)



Share of temporary method mix among under 20 total new acceptors, 2075/76

In the fiscal year 2075/76, more than half of method mix is occupied by depo (56%) followed by pills (35%), implant (7%) and IUCD (2%) for new acceptors under age 20 years. This is the proxy of modern contraceptives used by adolescent population (data for condom is not shown).

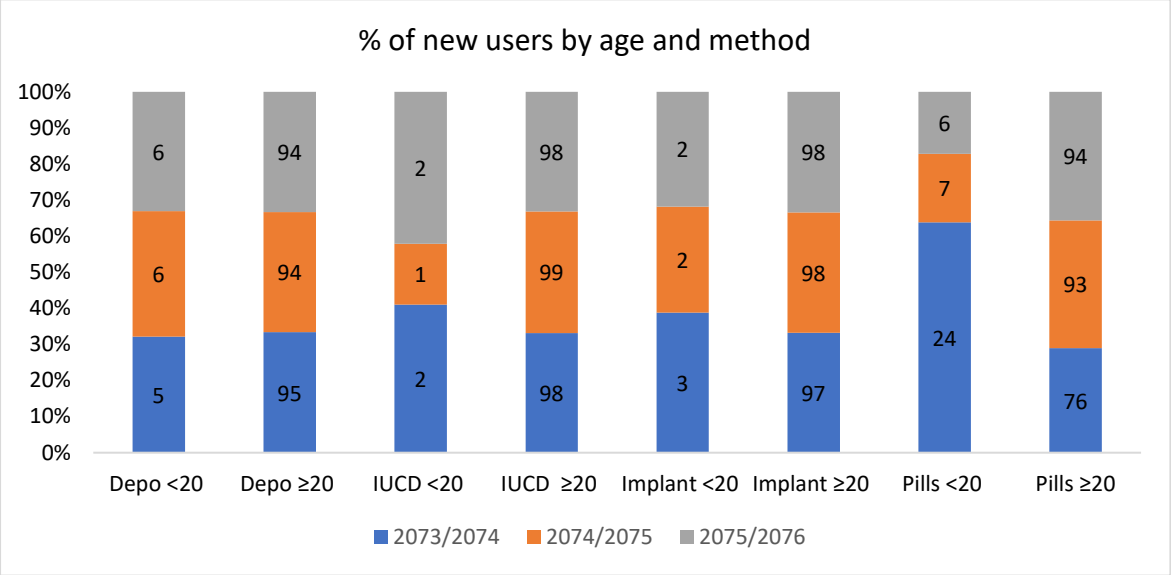
Figure 42: Method mix among under 20 yrs. (new acceptors)



Trend of new users of modern contraceptive, temporary method

It is observed that proportion of new users for depo below age 20 years increased in FY 2074/75 as compared for FY 2073/74 while it remained unchanged for fiscal year 2075/76 as 6% of total depo new users. Similarly, the proportion of pills new users decreased for the last three consecutive years for under 20 years among the total pills users. The details of modern contraceptive new users by method and age group is given in the following Figure 44.

Figure 43: Percentage of new users by age and method for FY 2073/74 to 2075/76



Issues, constraints and recommendations

Table 24: Issues, constraints and recommendations for FP program

Issues	Recommendations	Responsibility
• Inadequate access to and use of FP services by hard to reach communities including adolescents	• Implementation of FP microplanning in low mCPR wards/ municipalities • Mobilize VSPs for LARC services	MoSD, PHD, local governments
• Limited health facilities providing five contraceptive methods	• Conduct targeted mobile outreach and satellite clinics focusing on LARCs • Ensure availability of LARCs commodities • Improve delivery of quality of FP services	MoSD, PHLMC, PHTC, PHD
• High contraceptive discontinuation	• Improve FP education, information and services for adolescents including CSE • Introduction of school health nurse programme • Initiate and scale integrated FP/EPI clinics and postpartum and post-abortion services • Strengthen FP services in urban health and community health clinics	MoSD, PHLMC, PHTC, PHD, local governments
• Underutilized LARCs	• Strengthen FP services in private Hospital • Update the knowledge of FCHVs on LARC	MoSD, PHTC,PHD, local governments
• Inadequate trained human resources on LAPM	• Strengthen and expand the capacity of FP training sites •	,,

EPIDEMIOLOGY OUTBREAK AND DISASTER MANAGEMENT

Epidemiology is a science that studies the patterns, causes and efforts of health and diseases in defined populations. The Department of Health Service (DoHS), Epidemiology and Disease Control Division (EDCD) is actively working against epidemic-out break/disaster management. Provincial Health Directorate (PHD) is also actively working for this in province 2. Province, and district level Rapid Response Team (RRT) has been formed. As per the guideline palika level RRT need to be formed which is under the process. The RRT moves immediately to response the epidemic/outbreak condition for proper management of diseases control and management. In this situation, the main role of PHD is to manage the human resources, buffer stock of drugs, planning, and coordination to stakeholders, monitoring and supervision of these areas and treatment of the affected people as well.

Objectives

The overall objective is to enhance the capacities of health sector in emergency preparedness and response by focusing on disaster prevention, mitigation and through following activities;

- Expediting the process of health sector contingency planning.
- Provide training to the health workers in emergency preparedness and disaster response.
- Strengthen the mechanism for multi-sectoral coordination and collaboration in relation to health sector disaster management.

EDCD also supplied the necessary drugs and managed the anti-cholera vaccination activity to the local people. The health personnel of PHD and HO of the two these districts provided health educations regarding safe drinking water. Municipality, local level and local people were supplied safe drinking water to the affected areas.

Problems/Constraints

- No provision of regular reporting of epidemic outbreak and disaster management activities in HMIS.
- Budget allocation is inadequate.
- Health sector contingency planning for all districts and yearly regional level review meeting for review and update of contingency planning is not in priority
- No review and update of RRT guideline for provision of Community RRT.
- Inadequate guideline for formation of provincial and local level RRT.
- Palika-level RRT has not been formed in all the palika yet.

3.1 Vector-borne and neglected tropical diseases

3.1.1 Malaria

3.1.1.1 Background

Malaria is a priority public health problem of Nepal where approximately 43.3% of the population is at risk of malaria . The population and the area at risk of malaria have been shrinking over the years primarily as a result of effective and successful malaria programmed. Earlier the population living in a district was taken as the denominator but the most recent micro stratification, 2018 identified the population living in a ward as the denominator. There are pockets of areas within the village with ongoing transmission of malaria while other areas within the village are not conducive for malaria transmission. The high and moderate malaria risk areas consist of foothills, forests fringe, forests in Terai and inner Terai valleys, whereas the low risk area consist of southern planes and northern hills/ hill river valleys.

The trend of confirmed malaria cases during the last three decades show fluctuations, with a peak in 1985 when the number exceeded 42,321, representing the highest malaria case-load ever recorded in Nepal (1). This was followed by a steep decline each year till date with a few major outbreaks in between. The last outbreak occurred in 2006 in the villages of Banke accounting for 36 deaths. Although clinical malaria cases increased during the early years of the control phase, mostly due to scale up and expansion of community based integrated management of childhood illness (CBIMCI) programme throughout the nation, yet implementation of appropriate modification in the guidelines and ensuring increased access to diagnosis and treatment of malaria has contributed to a gradual decreasing trend in clinical malaria during the last few years (108,179 in 2010 versus 20,861 in 2014/15). Total confirmed malaria cases declined by approximately 90 % over a decade (12,750 cases in 2002 versus 1128 cases in 2016/17), while deaths have been reported a few in between 2011 till 2016 mostly imported cases. Three deaths were reported due to malaria reported in 2016 were imported from Africa and India. The proportion of Plasmodium falciparum (Pf) infection accounts for around 13% while 87% of the total cases are Plasmodium vivax (Pv) infections. The proportion of imported cases shows increasing trend throughout the last five years, which is a major challenge for the current elimination program.

Nepal has achieved and exceeded the malaria target of the Millennium Development Goals (MDGs) and universal coverage of malaria control interventions, and the Roll Back Malaria (RBM) targets of 2010. The country has made significant progress in controlling malaria transmission over the past decade. The gains are attributed mainly to a change in drug therapy from the custom sulphadoxime-pyremethamine (SP) therapy to Artemether and lumefrantine (AL), IRS in high-endemic foci, the distribution of LLINs in high-endemic areas, and other enabling factors such as strategic partnerships, socio-economic development and free health service delivery through government health institutions. In Nepal, the first malaria micro-stratification was limited to district level where a district was identified as the basic administrative unit. The population at risk of malaria was defined as the total population of the district. But, analyses of malaria information throughout the years from the districts do not support the view that the total population of the district are at risk since malaria is a focal disease and is usually seen in hard to reach population and marginalized community. Therefore, microstratification conducted in 2012 reached up to VDC level and micro-stratification conducted in 2016 provided the insight of malaria risk at ward level and this strategic information was very useful to the National Malaria Program to target effective interventions at ward level. The recent study on 2018 concluded that 67 districts out of the 77 districts and about 43.26% of the total population are residing in areas at risk (high, moderate and low) of malaria. It further streamlined that 202 wards in 20 districts (as per new federal structure) are at high or moderate risk of malaria. Approximately 3.96%

of total population are living in malaria endemic (high and moderate risk) areas. Among them, 0.22 million live in high-risk areas (49 wards), 0.93 million in moderate risk areas (253 wards) and 11.34 million in low risk areas (2543 wards). The high and moderate risk areas include foothills, forests fringe areas, forests in Terai and inner Terai valleys as well as upper hilly river valley of mountainous districts, whereas the low risk area consist of southern plains and northern hills/ hill river valleys.

A ward may be geographically diverse and distinct in ecology and land use; people living in hill top settlement but working down in their fields in foothills and at times sleeping there to guard their crops, or some parts of the wards lying close to the forest while other parts of the ward may be a day or two days walk from the forested area. Furthermore, the ecological and entomological context may be different in such a diverse geographical spread and generalization may not be appropriate since the hill tops sloping environment may not sustain mosquitoes because of low temperatures and fast-moving streams despite adequate rainfall and humidity. However, the plain area in the foothills may be ideal for vector breeding with appropriate temperature and rainfall and slow-moving streams. A review of malaria information since the last three years reveal that even within a ward, malaria is concentrated within some tole while other toles are not affected at all. As per the recommendation of MTR 2013, microstratification has been conducting in ward lever in order to refine the risk stratification at the community level and thereby define the total population at risk of malaria. The current micro-stratification has adopted and aligned the recommendations generated in earlier micro-stratification to further refine the risk at an even smaller administrative unit.

3.1.1.2 Objectives:

- Prevention of mortality due to malaria;
- Reduction in malaria morbidity.
- Prevention and control of epidemics with reference to *Plasmodium falciparum* (PF)
- Community mobilization and community partnership in malaria control.

3.1.1.3 Targets:

Reduce or contain the Annual Parasite Incidence (API) at the level of 1/1000 population in malaria risk areas.

3.1.1.4 Indicator

Main Indicators	Calculation
Annual Blood Examination Rate (ABER)	$\frac{Total\ No.of\ slides\ examined}{Total\ Population\ at\ risk} x100$
Slide Positivity Rate (SPR)	$\frac{Total\ No.of\ positive\ cases}{Total\ slides\ examined} x100$
Annual Parasite Incidence (API)	$\frac{Total\ No.of\ positive\ cases}{Total\ population\ at\ risk} x1000$
Proportion of PF cases	$\frac{Total\ No.of\ PF\ cases}{Total\ positive\ cases} x100$

3.1.1.5 Analysis of Achievement

3.1.1.5.1 Annual blood slide examination rate

Annual blood slide examination rate has been shown of Province 2. Annual blood slide examination rate (ABER) at provincial level is reported 0.5 percent of total at risk population in FY 2075/76, and is at 0.2 percent as of latest 2074/75 records. The ABER is found fluctuating in a irregular pattern throughout the past five years.

The highest ABER in FY 2075/76 was reported from Parsa district with 1.72%, it is followed by Bara, Saptari, Siraha, Dhanusha, Rautahat, Sarlahi and Mahottari. All other districts ABER is less than 0.9% except Parsa.

Table 25: Blood slide examination rate, slide positivity rate andmalaria parasite incidence

Districts	*Annual Blood Slide Examination Rate(ABER)*			*Slide Positivity Rate (SPR)*			*Annual Parasite Incidence per 1,000 at risk population*		
	2073/74	2074/75	2075/76	2073/74	2074/75	2075/76	2073/74	2074/75	2075/76
Saptari	0.78	1.07	0.8	0.65	0.08	0.11	0.04	0.004	0.0012
Siraha	0.64	0.064	0.38	2.52	0.43	0.64	0.16	0.02	0.006
Dhanusha	1.56	0.7	0.63	0.38	0.33	0.27	0.05	0.02	0.0029
Mahottari	1.42	2.56	1.21	0.22	0.75	0.03	0.01	0.006	0.000
Sarlahi	0.17	0.21	0.1	0.27	0.43	0.15	0.01	0.01	0.0037
Rautahat	0.4	0.45	0.35	3.03	0.91	0.47	0.03	0.014	0.0091
Parsa	0.03	0.53	0.57	0	0.34	0.25	0	0.006	0.0029
Bara	0.47	1.16	0.59	0.46	0.65	0.24	0.04	0.01	0.00
Province Total	**0.6**	**0.8**	**0.5**	**0.9**	**0.4**	**0.2**	**0.04**	**0.01**	**0.0034**

3.1.1.5.2 Slide Positivity Rate (SPR)

Slide positive rate in the province, during FY 075/76, has decreased extremely which is 0.2% which was 0.4 % in the previously fiscal year. SPR was highest during 2071/72 with 4.5% reported during that period. Out of the 8 districts Parsa have not reported the least positive malaria cases in this fiscal year 2075/76 and Dhanusha has reported the highest with 0.64 percent in 2075/76. In total 60 positive cases was reported in 2075/76 from Province 2, in which Dhanusha reported the highest number of positive cases (18) followed by Sarlahi (13), Saptari (7), Siraha (6) and Mahottari, Rautahat, Bara and Parsa reported 4 cases each in the fiscal year 2076/76.

3.1.1.5.3 Annual Parasite Incidence (API)

According to the Table 25, Malaria Parasite Incidence per 1000 risk population of Province 2 is 0.0034 in FY 2075/76, which is found to be in decreasing trend as we observe till 2074/75. The highest is observed in Sarlahi with 0.0091 in 2075/76 and least from Parsa district, which is also the lowest for five consecutive fiscal years.

3.1.1.6 Issues and Recommendations

Table 26: Issues, recommendations for Malaria Control Program

Issues	Recommendations	Responsibility
Identification of Malaria risk population	Detailed study should be done	EDCD
Low quality and coverage of spraying activities	Increase coverage of spraying activities	PHD EDCD/ Ento-team
Less coordination between the microscopic networks and collection centre	Trimester meeting should be introduced Strengthen the way of carrier movement	EDCD EDCD/PHD/HOs
Inconsistency of reported malaria data	HMIS and Program data should be consistent at district and center	EDCD/PHD/HOs

3.1.2 Kala-azar

3.1.2.1 Background

Kala-azar is major a public health problem in Nepal. The first cases of kala-azar were reported in Nepal as early as 1960. The program initially identified 12 districts of central and eastern terai region as Kala-azar endemic of Nepal. **6** other districts were included in the list in 2016 because sporadic cases were consistently being reported by these 6 districts. Currently **18 districts** are considered endemic. More than 6 million people in Nepal are believed to be at risk of this disease. All the districts of province 2 have been affected by kala-azar.

Goal

- Reduce incidence of Kala-azar to less than one case per 10,000 population at district level by the year 2017 or before

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 PKDL to reduce the parasite reservoir and
- Prevention and treatment of kala-azar and HIV-TB co-infections

3.1.2.2 Indicators

	Main Indicators	Calculation
1	Kala-azar incidence (KAI)	$\frac{\text{Total Kala} - \text{azar New Cases}}{\text{Total population at risk}} x100{,}00$
2	Reported case fatality rate (CFR)	$\frac{\text{Total Kala} - \text{azar Deaths}}{\text{Total Kala} - \text{azar Cases}} x100$

3.1.2.3 Trend of Kala-azar cases

Kala-azar was one of the major public health problems in the province as almost half of the total reported cases were accounted in this province. From the last two consequent years the recorded numbers of cases were decreasing in districts of province 2.

Table 27: Trend Kala-azar/Leshmaniasis positive cases

District	*2073/74*	*2074/75*	*2075/076*
Saptari	6	4	0
Siraha	15	11	0
Dhanusha	15	2	5
Mahottari	11	8	0
Sarlahi	24	17	1
Rautahat	1	2	0
Bara	1	1	0
Parsa	1	0	0
Province Total	**74**	**45**	**6**

Source: EWARS, EDCD

3.1.2.4 Death due to kala-azar

No deaths from Kala-azar were reported in past three years in any of the districts. This can be because of effective implementation of Kala azar program in the province. Some probability of under reporting from the districts also exists.

3.1.2.5 Issues and Recommendations

Table 27: Issues, recommendations for Kala-azar program

Issues	Recommendations	Responsibility
Availability of K39 dipstick diagnosis tests in PHCC level	Expansion to all PHCC level	EDCD/ LMD
Physicians and other paramedics are unaware of Kala-azar treatment protocol	Training/Orientation should be given	EDCD/PHD
Weak monitoring system and follow up of Kala-azar patients	Develop and introduce follow-up system of kala-azar patients	EDCD/PHD/Districts

3.1.3 Dengue

3.1.3.1 Background

Dengue fever is the most important mosquito borne viral disease and a major international public health concern. This mosquito-borne disease emerged in Nepal showing its head as Dengue Fever (DF), Dengue Haemorrhagic Fever (DHF) and Dengue Shock Syndrome (DSS). *Aedes aegipti* (mosquito-vector) has been identified in peri-urban areas in the Terai of Central Region. During the entomological surveillance, conducted by EDCD/CDR in FY 2066/67 to 2069/70, indicated local transmission of dengue. Studies carried out by EDCD/NPHL in close collaboration of WARUN/AFRIMS showed that all 4 sub-types (DEN-1, DEN-2, DEN-3 and DEN-4) of dengue virus circulation are common in Nepal.

Goal

To reduce the morbidity due Dengue Fever (DF), Dengue Haemorrhagic Fever (DHF) and Dengue Shock Syndrome (DSS).

Objectives

- To develop an integrated vector control approach for prevention and control
- To develop capacity on diagnosis and case management of DF/DHF/DSS
- To intensify health education/IEC activities and
- To strengthen the surveillance system for prediction, early detection, preparedness and early response to outbreak of dengue.

Based on the outbreaks, operational research and response carried out in the past, Province Government adopted the following strategy developed by Government of Nepal for the control of dengue:

1. Early case detection, diagnosis, management and reporting of the DF/DHF/DSS.
2. Regular surveillance of DF/DHF/DSS through EWARS.
3. Regular vector surveillance.

3.1.3.2 Dengue cases

The Table 28 shows in FY 2075/76 with 12 confirmed dengue cases in province 2, highest cases were reported in Saptari district with 4 cases. Mahottari, Parsa and Siraha reported one case each. Rest of the district did not report any confirmed cases of Dengue.

Table 28: Number of Dengue positive cases in FY 2073/74 to 2075/76

District	***2073/74***	***2074/75***	***2075/076***
Saptari	0	2	4
Siraha	0	1	1
Dhanusha	27	0	0
Mahottari	438	3	3
Sarlahi	130	2	0
Rautahat	12	1	0
Bara	2	1	0
Parsa	0	2	4
Province Total	**609**	**12**	**12**

Source: EWARS, EDCD

3.1.3.3 Issues and Recommendations

Table 29: Issues, recommendations for Dengue program

Issues	Recommendations	Responsibility
Inadequate dengue control interventions in districts	• Increase budget • Orientation for all level • Strategy development and planning • Advocacy • Vector management	EDCD

3.1.4 Lymphatic Filariasis

3.1.4.1 Background

In Nepal the principal parasite responsible for lymphatic filariasis is *Wucheria* bancrofti. The primary vector of transmission is *Culex quniquefasciatus*. The adult worms (macrofilariae) are located in the lymphatic system of the human host, where they live for 5–10 years. After mating with male worms, female worms can produce millions of microfilariae (mf), which can be found in the human blood circulation and have a lifespan of 6–24 months. A mosquito that takes a blood meal may engorge some micro filaria. Inside the mosquito, mf is developed in about 12 days into L3 stage larvae (L3), which are infectious to human. When the mosquito takes another blood meal, the L3 larvae can enter the human body and some will migrate to the lymphatic system and will develop into mature adult worms. The immature period lasts about 6–12 months. MF cannot develop into adult worms without passing through the developmental stages in the mosquito. Larval development and mosquito survival are density dependent.

Goal

- People of Nepal no longer suffer LF

Objectives

- To eliminate LF as a public health problem by 2010
- To interrupt the transmission of lymphatic filariasis
- To reduce and prevent morbidity
- To provide de-worming benefit through use of Abendazole to endemic community to the children and
- To reduce mosquito vector through application of suitable and available vector control measures.

Strategy

- Interruption of transmission by yearly Mass Drug Administration (MDA) using two drug regimens for six years.
- Morbidity management by self- help and with support using intensive but simple, effective and local hygienic techniques.

Target

- To cover with MDA all LF endemic districts by 2014 and achieve <1% prevalence in all endemic district after 5 years of MDA by 2018.

3.1.4.2 Major Activities

- At Provincial level
  - Provincial level planning meeting
  - Supervision and Monitoring
- Activities at District level
  - Medicine supply by central medical store via health office
- Activities at Palika level
  - Training to health workers
  - Volunteers orientation
  - Advocacy/social mobilization
  - Implementation of MDA activities

3.1.4.3 Issues and Recommendations

Issues	Recommendations	Responsibility
• MDA related severe adverse events management • LF related morbidity management • Poor MDA achievement in urban	• Increase budget • Training • Social mobilization • Media management • SAE management	• MoHP/EDCD

3.1.5 Leprosy

3.1.5.1 Background

Leprosy has existed in Nepal since time immemorial and was recognized as a major Public Health problem as early as 1950. Khokana Leprosarium near Kathmandu was established more than 160 years ago to provide services to the leprosy patients. Leprosy control activities initiated in 1960. A pilot project commenced in 1966 based on Dapsonemono therapy, which was gradually expanded to more areas in the form of vertical leprosy control program. Multi- Drug Therapy (MDT) was initiated in few selected areas and hospital in 1982/83, substituting Dapsonemono therapy and steadily covering 75 districts in 1996. MDT has been proved to be safe, effective and well accepted. World Health Assembly in 1991 passed a resolution for global elimination of leprosy by the end of year 2000 and it was eliminated in 2010. Nepal is an active member of the global alliance for elimination of leprosy as a public health problem.

Vision: To make a leprosy-free society where there is no new leprosy case and all the needs of existing leprosy affected persons having been fully met.

Mission: To provide accessible and acceptable cost-effective quality leprosy services including rehabilitation and continue to provide such services as long as and wherever needed.

Goal: Reduce further burden of leprosy and to break channel of transmission of leprosy from person to person 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 the district level.
- To reduce disability due to leprosy.
- To reduce stigma in the community against leprosy.
- To provide high-quality service for all persons affected by leprosy.
- To integrate leprosy in the integrated health care delivery set-up for the provision of quality services.

Strategies

The national strategy envisions delivering quality leprosy services through greater participation and meaningful involvement of people affected by leprosy and right based approaches in leprosy services as follows:

- Early new case detection and their timely and complete management
- Quality leprosy services in an integrated setup by qualified health workers
- Prevention of impairment and disability associated with leprosy
- Rehabilitation of people affected by leprosy, including medical and community-based rehabilitation
- Reduce stigma and discrimination through advocacy, social mobilization, IEC activities and address gender equality and social inclusion
- Strengthen referral centers for complications management
- Meaningful involvement of people affected by leprosy in leprosy services and address human right issues
- Promote and conduct operational researches/studies
- Monitoring, supportive supervision including onsite coaching, surveillance and evaluation to ensure/strengthen quality leprosy services

- Strengthen partnership, co-operation, coordination with local government, external development partners, civil society and community-based organizations.

Targets

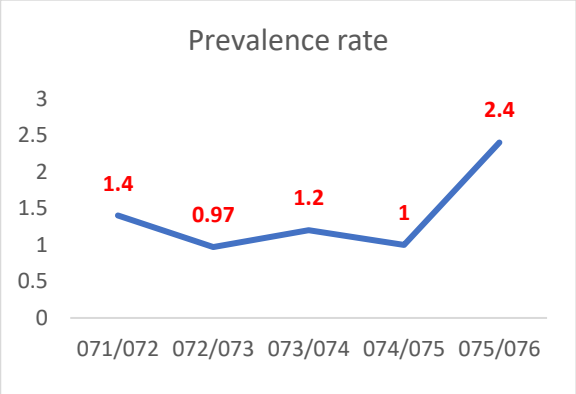
- Reduce New Case Detection Rate (NCDR) by 25 % at the national level by the end of 2015 in comparison to 2010
- Reduce Prevalence Rate (PR) by 35 % at national level by the end of 2015 in comparison to 2010
- Reduce by 35% Grade 2 disability (G2D) amongst newly detected cases per 100,000 population by the end of 2015 in comparison to 2010
- Additional deformity during treatment <5% by eyes,hands and feet (EHF) score o 80% health workers are able to recognize and manage /refer reaction/complications o Promote prevention of disability in leprosy(POD)and Self-care

3.1.5.2 Analysis of Achievement

3.1.5.2.1 Prevalence

The prevalence rate of leprosy is recorded 2.4 per 10,000 populations at the province. This rate is above 1 per 10,000 populations. There has been increasing trend of leprosy in the province. However, 7 out of 8 districts in the province still reported prevalence rate above 1 per 10000 populations. Highest prevalence was recorded in dhanusha district with 4 cases per 10,000. Trend of prevalence rate of leprosy is shown in the Figure 44.

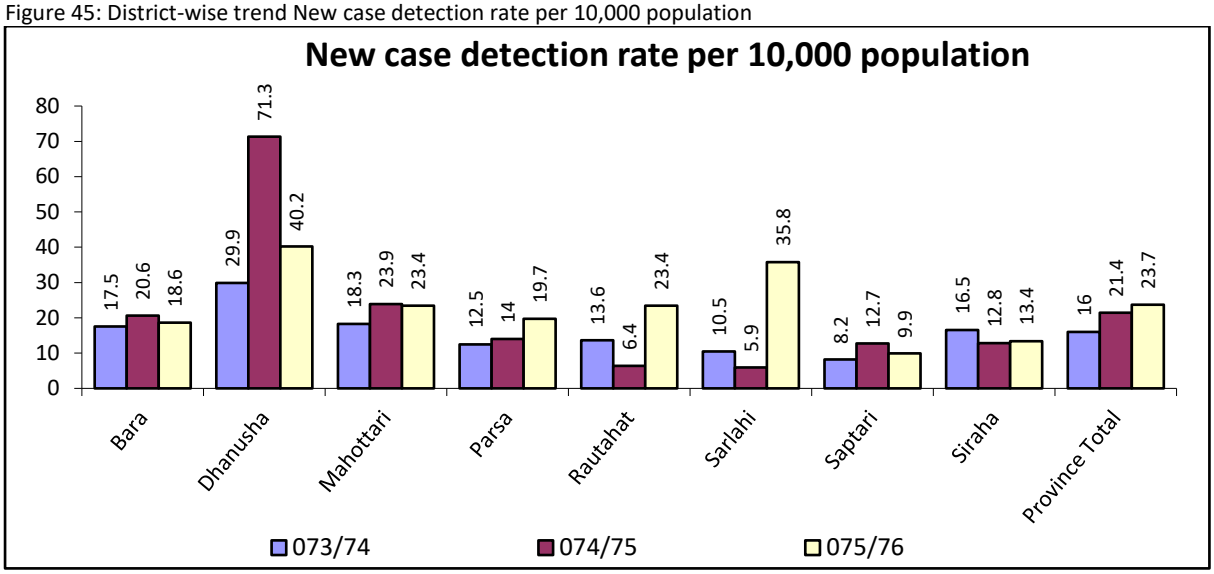
Figure 44: Trend of prevalence rate



3.1.5.2.2 New case detection

New Case Detection Rate (NCDR) at the provincial level is 23.7 per 10,000 populations in FY 2075/76 which shows gradual increase in comparison to the previous years. As shown in the Figure 45, NCDR was highest for Dhanusha. Lowest NCDR is recorded for Saptari district. There has been peak rise in NCDR of Sarlahi which indicates focused interventions to search more cases and treat them properly. Dhanusha has consistently high NCDR in the long race of three years trend.

Figure 45: District-wise trend New case detection rate per 10,000 population



Thirteen thousand Five Hundred and fifty-six new leprosy cases were detected during this reporting year (2075/76), which is drastic increase in number and rate as compared to previous reporting years. The highest number was reported from Dhanusha with 2734 cases followed by Sarlahi 2643, Bara 2022, Rautahat 1642, Mahottari 1580, Parsa 1085, Siraha 984 and Saptari 866 new cases respectively. Female proportion was recorded to be almost 50% of the new cases while 11.7% were child cases. Grade II disability was found to be reduced in comparison to the previous year.

Table 30: New case detection of leprosy and proportion

Fiscal year	*New cases*			*Proportion among new cases*		
	MB	**PB**	**Total**	**Female**	**Child**	**Dis. Grade II**
2073/74			9919	42.1	13.5	4.2
2074/75			8719	48.1	12.6	6.1
2075/76			13556	50.1	11.7	4.6

3.1.5.2.3 Disability Grade II proportion

Table 31: Disability Grade-II Proportion

Districts	***2073/74***	***2074/75***	***2075/76***
Bara	1.5	3.1	2
Dhanusha	5.4	8.6	4.2
Mahottari	8.1	2.4	6.7
Parsa	0	3.1	2.2
Rautahat	3.8	2	1
Sarlahi	2.2	0	3.8
Saptari	14.3	9.1	20.3
Siraha	0.89	8	7.5
Province	**4.2**	**6.1**	**4.6**

As shown in the Table 31, the proportion of disability grade II among new cases has decreased in comparison to previous year. The proportion has decreased in this reporting year to 4.6 from 6.1 in 2074/75.

In this reporting year, Saptari accounts for the highest proportion (20.3%) of disability grade II. This proportion has drastically increased in the district from 9.1 percent in 2074/75 to 20.3 percent in 2075/76. Likewise Mahottari also reported increasing proportion of the disability grade II. However Bara, Dhanusha, Parsa, Rautahat and Siraha districts are able to inverse grade II disability among new cases in the FY 2075/76.

3.1.5.3 Issues and Recommendations

Issues	Recommendations	Responsibility
High prevalence in some districts	Develop and implement target specific program	LCD/HD
Inadequate trained MO at district level	One MO should be trained as focal person for case validation (each district)	HD/Partners
Lack of Urban leprosy Program	Urban health program should be included in Leprosy elimination strategy and program	MoHP/DoHS/LCD
Insufficient self help group	Self help group should be promoted	LCD
Inadequate R/R from Mohattari andRautahat	Master register should be Prepared and Data verification in those district	LCD/HD/District/Partners

3.2 Tuberculosis

3.2.1 Background

Tuberculosis remains a public health problem In Nepal. TB is one of the Nepal's top health challenges. It is estimated that nearly 15 million populations, equals to almost half of the Nepal's total population are infected with TB. It is estimated that early 44000 new cases of active TB occur in the country annually, with nearly 5000-8000 deaths because of it. Male are found to develop TB disease nearly twice as more than female. Each day in Nepal; nearly there are nearly 120 new cases of TB occur, nearly 20 deaths happen because of TB and nearly 25 cases that are missed to be diagnosed of TB. Without treatment, nearly 22,000 people would die from TB in Nepal over the next two years. If the DOTS program is well maintained as planned, the number of deaths in this period will be reduced by 75%.

NTP implemented DOTS strategy since 1996 and adopted Stop TB Strategy in 2006. With the end of MDG era in 2015, NTP has now entered a new era of END TB STRATEGY with aims to end the global TB epidemic, with targets to reduce TB deaths by 95% and to cut new cases by 90% between 2015 and 2035, and to ensure that no family is burdened with catastrophic expenses due to TB. This Strategy sets out directions to achieve NTP goals and targets set for the coming years.

Estimated burden of TB in province 2 is approximately 9300 TB cases. This is calculated based on the current incidence rate of TB in Nepal.

Coverage of TB services has been made widely accessible through provision of DOTS from 828 treatment centres, sputum examination from 73 microscopy centres and 10 GeneXpert centres in Province No. 2.

Vision of National Tuberculosis Program is "TB free Nepal".

Goal

- To reduce mortality, morbidity and transmission rate of Tuberculosis until it is no longer a public health problem and ultimately to eliminate TB

Objectives

- To reduce the incidence of TB by 20% by 2021 and 90% by 2035
- To reduce the TB deaths by 35% by 2020 and 95% by 2035
- To reduce the catastrophic cost to families due to TB to 0% by 2035

Targets

INDICATORS/MILESTONES	***MILESTONES***		***TARGETS***	
	2020	**2025**	**2030**	**2035**
Percentage reduction in the absolute number of TB deaths (Compared number of TB deaths)	35	75	90	95
Percentage reduction in the TB incidence rate (compared with 2015 baseline)	20	50	80	90 (10/ 100000)
Percentage of catastrophic expenditure	0	0	0	0

3.2.2 Major Activities

- Conducted TB coordination meetings with different stakeholders and partners.
- Celebrated World TB Day with different IEC/BCC and advocacy activities.

- Conducted TB modular/refresher and lab modular/refresher training for health workers.
- Expansion of microscopic centres and DOTS centres and DR centres.
- Carried out Advocacy Communication and Social Mobilization (ACSM) activities.
- Provided DOTS to all patients.
- Promoted early diagnosis of TB cases through active case finding modality like sputum transportation, contact tracing, screening TB in SAM/MAM and severe ARI cases.
- Implemented FAST strategy in Narayani Sub Regional Hospital
- Established cough screening desk (CSD) in different private health facilities of Parsa and Dhanusha to increase TB case notification
- Continued a system of quality control of sputum smear examination.
- Provided continuous drugs supply to all treatment centres ensuring proper 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 program.
- Strengthened coordination with private sectors, non-government organizations and External Development Partners.
- Conduct review of DS and DR-TB

3.2.3 Analysis of Achievement

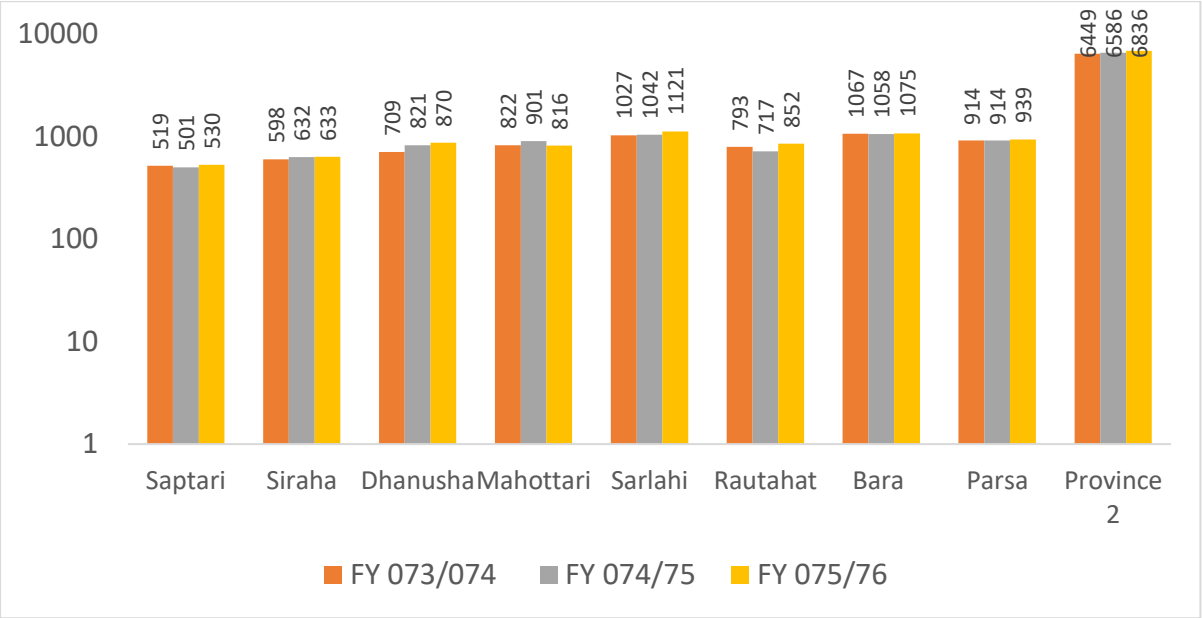
3.2.3.1 Expansion of Services

TB services in the province are being provided through 828 DOTS Treatment centres, 73 microscopic centres and 10 GeneXpert centres. Along with government sector, other partners involved in the implementation of TB programs in the province include private hospitals, nursing homes/polyclinics, prisons, I/NGO like Save the Children, Bagmati Welfare Society (BWSN), Birat Nepal Medical Trust (BNMT) and *Sahayog Samittee Nepal* (SSN). Urban DOTS program has been introduced in some urban areas of the districts in coordination with the respective local levels.

3.2.3.2 Case Notification

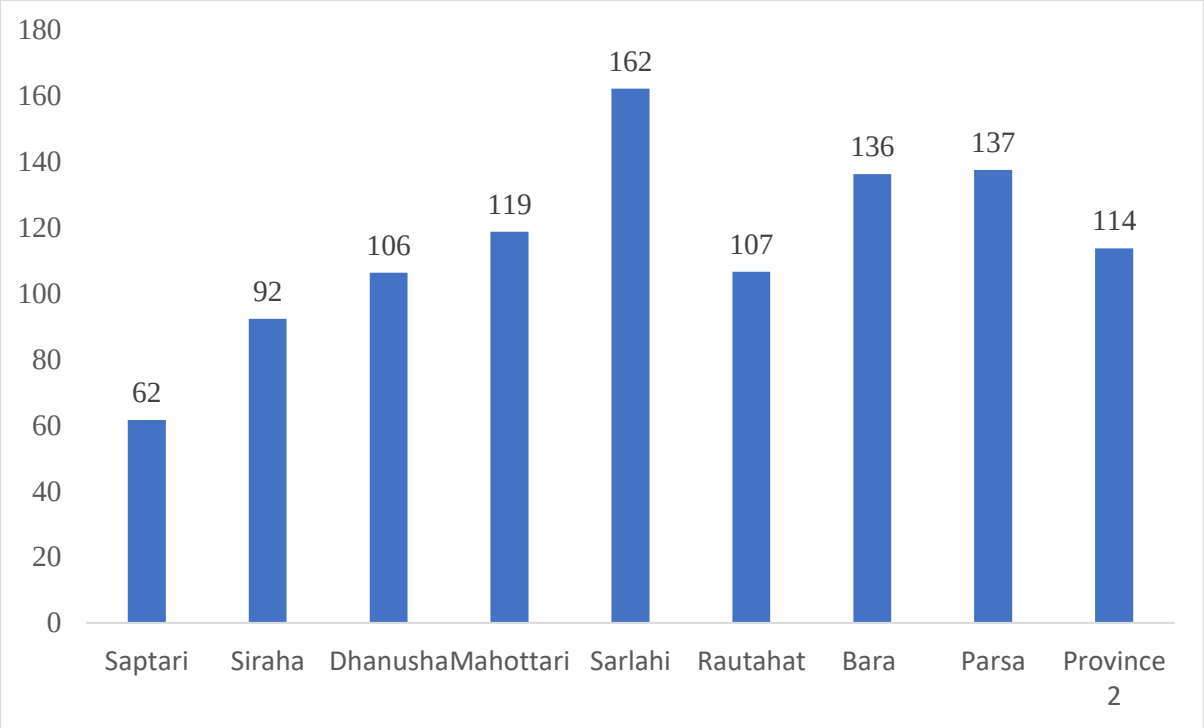
In the reporting year a total of 6836 TB cases were diagnosed of which 6351 are new TB cases. 36% (2282) of the total new TB cases were female and 64% (4069) were male. 3715 cases were new pulmonary bacteriological confirmed (PBC) cases. Child TB cases account for 6% (403) of all TB cases. Comparison of TB cases notified in the last years shows gradual increase in the trend.

Figure 46: Three years trend of TB Case Notification



Case Notification Rate (CNR), all form, in province 2 remains consistently below the national level which is inadequate to meet the target of End TB Strategy. Overall CNR in province 2 has been reported to be 114 per 100000 populations. On three years trend, CNR is consistently low which advocates implementation of novel strategy of case detections to reach the unreached presumptive TB cases. Ecologically, Sarlahi accounts for highest case notification rate of 162 and Saptari accounts for the lowest CNR of 62 TB cases per 100000 populations. Based on CNR, Bara, Mahottari, Parsa and Sarlahi are showing good performance while Dhanusha, Siraha, Saptari and Rautahat are poor performing districts.

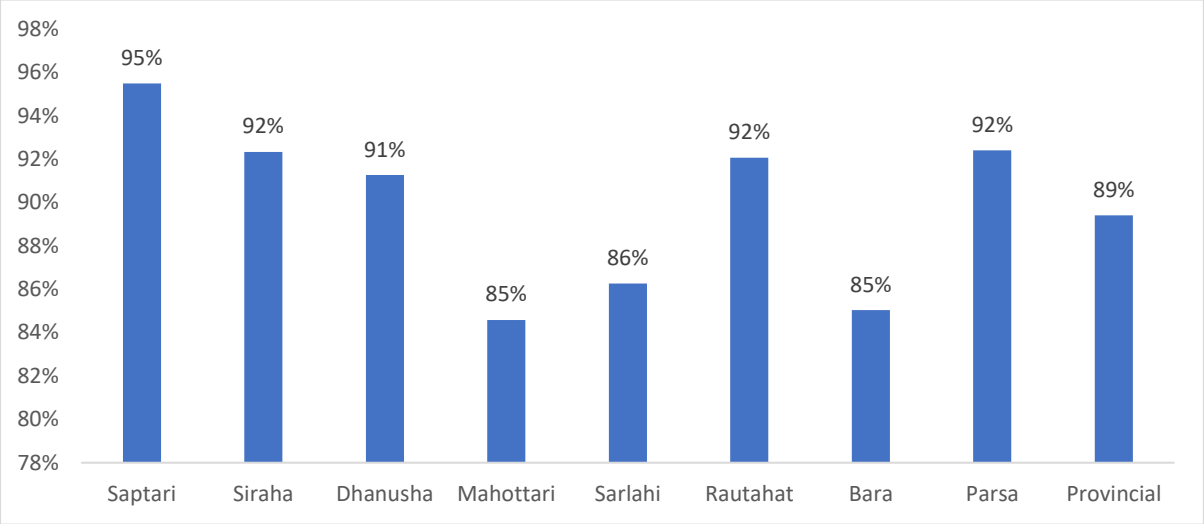
Figure 47: Case finding rate (all forms of TB)



3.2.3.3 Sputum conversion

Sputum Conversion is used to monitor indicator for case management in national tuberculosis control program. Sputum conversion rate by district is shown in the figure 48. The reported sputum conversion rate at the provincial level in 2075/76 for new PBC case is 89% which is slightly below the standard of NTP. The sputum conversion rate has maintained its trend as per previous years. In spite of better case notification in Bara, Sarlahi and Mahottari, sputum conversion rate of these districts are poor stating poor case management. Dhanusha, Parsa, Rautahat, Saptari and Siraha has better conversion rate above 90%.

Figure 48: Sputum conversion rate (New PBC)



3.2.3.4 Treatment outcome

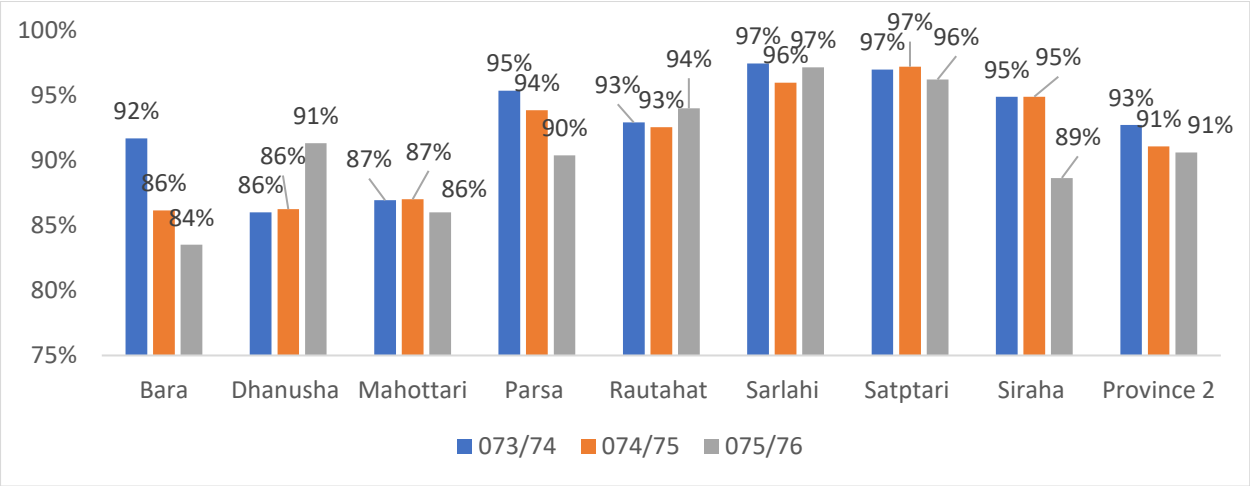
Among 3383 new pulmonary bacteriological confirmed (PBC) registered cases, 2682 cases were cured in this reporting year making the cure rate of the province 79 percent. Similarly, the treatment success rate of the new PBC cases in the province stands at 91 percent.

NTP has targeted to achieve treatment success rate of more than 90%. The province has maintained consistent level of treatment success rate over the years as shown in the Table 32. Majority of the districts (5) have achieved target for the treatment success rate while 3 districts viz. Bara, Dhanusha and Mahottari reported treatment success rate less than 90%.

Table 32: Treatment outcome for TB, FY 2075/76

	New			***Retreatment PBC***
	PBC	**PCD**	**EP**	
Registered cases	3383	1277	1221	385
Cured	2682			297
Completed	384	1104	1138	49
Failure	22	7	0	2
Died	118	22	20	15
Loss to follow up	133	31	38	19
Not Evaluated	23	48	16	3
Cure Rate	79%			77%
Success Rate	91%	91%	93%	90%

Figure 49: Treatment Success Rate



3.2.3.5 Drug Resistant (DR) TB Management

Table 33: DR TB treatment sites in Province 2

S. No.	*DR treatment center*	*Number*
1	Lalgadh hospital	8
2	National Medical college	2
3	Chapur Hospital	2
4	Center in province 1 but sub-centre in province 2	5
	Total	**17**

At present, there are 3 treatment centres and 17 sub centres in province 2 providing DR TB management services. Rapid Drug Susceptibly Testing (DST) are also being provided through 10 GeneXpert Centres in the province. This is useful for diagnosis of TB and detection of Rifampicin Resistant (RR) TB cases. In the province there is a DR hotel for treatment of DR TB cases. In FY 075/76, 54 RR and 5 Pre XDR and 1 XDR TB cases were diagnosed and enrolled for treatment.

Table 34: DR TB Management

RR			*Pre XDR*			*XDR*		
F	**M**	**T**	**F**	**M**	**T**	**F**	**M**	**T**
14	42	56	2	4	6	0	0	0
Treatment outcome						**Cured Rate**		
Cured					33	**53.22%**		
Complete					0			
Died					12			
Lost to follow up					8			
Not Evaluated					1			
Shifted to Pre XDR					5			
Shifted to XDR					3			
Total					62			

There was a total of 62 DR TB patients (Female-16 and male-46) under treatment in the province in this reporting year. The number of RR TB patients registered was 56. Among them, 14 were female and 42 were male. Cure rate of the DR TB in this reporting year is 53.2 percent. One DR TB hostel is being operated in the province which is in Dhanusha district.

3.2.3.6 Issues and Recommendations

Table 35: Issues, recommendations for TB program

Issues	Recommendations	Responsibility
Low case notification rate	• Strengthen Sputum Collection and Transportation system from health facilities to dedicated Microscopy centres • Focus on TB screening among children with SAM/MAM and ARI • Increase testing of presumptive TB cases through GeneXpert technology • Effectively engage private practiceneers of TB case notification • Increase ACSM activities • Active case finding of vulnerable groups and pocket areas • Strengthen contact tracing • Expand urban DOTS	NTC/HD/HOs
TB-HIV co-infection management	• Strengthen TB/HIV collaboration	NTC
DR TB management	• Strengthen DOTS and follow up • Strengthen PPM to improve proper and timely referral, diagnosis and treatment • Expand DR TB centres • Expand GeneXpert centres	NTC/CRHD

3.3 HIV/AIDS and STI

3.3.1 Background

Over the years HIV has been stabilized as a concentrated epidemic in Nepal, which is characterized by more than 5% HIV infection rates for certain key population at higher risk (e.g. PWID) and less than 1% HIV prevalence rate in general population. Since the first case of HIV infection was identified in 1988, Nepal has been able to make some substantial progress in National HIV & AIDS response; nevertheless, still, there is a lot to do. The HIV prevalence among adult population (15-49 years) has been declined by 50% i.e. from 0.2% in 2010 to 0.14% in 2018 and 63% reduction in HIV incidence per 1000 population of new HIV infection (0.08 in 2010 and 0.03 in 2018).

A new National HIV Strategic Plan 2016-2021 is recently launched to achieve ambitious global goals of 90-90-90 i.e. By 2020, 90% of all people living with HIV (PLHIV) will know their HIV status, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy (ART) and 90% of all people receiving antiretroviral therapy will have viral suppression. Activities in provincial level were also planned and executed in line to achieve the national goal.

Over the past few years, HIV related services has been scaled up in all 08 districts and CB-PMTCT services has been scaled up to all health facilities of Province 02. Total 08 ART sites (01 site in each district of Prov02) are offering Anti-retroviral Therapy (ART) services in the districts. Total 08 HTC sites (01 site in each district) are providing HIV testing and counseling service and 03 sites (Ga. Na. Singh Hospital, Rajbiraj, Provincial Hospital, Janakpurdham and Narayani Hospital, Birgunj) are providing CD4 test facilities to the PLHIVs. Narayani hospital is only the site providing Opioid Substitution Therapy (OST) services in this province. Targeted Intervention (PWIDs, Migrants, Prison inmates, FSWs, MSM/TG) for HIV program are also implementing in all the districts of Province 02. Likewise, Care & Support program (CHBC & CCC) for PLHIV are also supporting towards the national HIV responses. HIV patients has been benefitted for viral load testing service through sample collection from ART sites and sending it to the NPHL through courier and later receive the result. EID samples of the baby have also been collecting from the delivery sites, mostly from the ART sites and sending it to NPHL and receive the result.
The following were the major activities undertaken under HIV/AIDS & STDs control program in FY 2075/76:

- Provided HIV testing and counseling services through HTC sites
- Provided antiretroviral therapy through ART sites
- CB-PMTCT services
- Targeted Intervention (PWID, MSM, FSWs, Migrants, Prison inmates)
- Celebrated World AIDS Day and Condom Day
- Viral load sample collection

3.3.2 Analysis of Achievement

3.3.2.1 HIV Testing and Counselling (HTC)

HIV testing and counseling (HTC) offers an important entry point to prevention, care and support services. It is an essential component of comprehensive programming of response to HIV. HTC service is the process of providing people with professional counseling before and after an HIV test. The process helps people prepare for and understand their HIV test results. It is a powerful strategy that can equip people with knowledge and skills for sustainable healthy behavior. HIV testing and counseling of HIV was first started in Nepal in 1995 at NCASC. As of now, there are altogether 8 sites all over the province including govt. as well as INGO/NGO/CBOs. HIV testing and counseling services is provided free of cost to the key populations at higher risk to HIV including general population from

all over the country according the national HTC guidelines. The guidelines for HIV testing and counseling was first developed in 2003 and updated in 2007, and 2010.

Table 36: HIV/AIDS and STI program achievement, FY 2073/74 to 2076/77

Districts	HIV Testing and Counselling Vs Positive					
	FY 073/074		074/075		075/076	
	Tested	Positive	Tested	Positive	Tested	Positive
BARA	4316	24	5393	53	5889	42
DHANUSA	1206	64	2602	71	4243	70
MAHOTTARI	2735	17	5234	57	7378	52
PARSA	2449	88	3431	84	2588	31
RAUTAHAT	2099	40	5280	34	6910	46
SAPTARI	331	10	1719	11	2902	6
SARLAHI	4247	19	5614	29	8029	74
SIRAHA	1007	32	2988	29	4103	52
Province Total	**18390**	**294**	**32261**	**368**	**42042**	**373**

The last three years' data from HIV testing and counselling services shows a trend of gradual increasement in testing as well as positivity yield. In fiscal year 074/75 the testing increased nearly by 1.8 times and there was remarkable increase in the yield rate as well in comparison to FY 073/074. Testing gradually increased to 42042 persons in FY 075/076 with 373 people identified to have HIV infection. However, it is critical to have more HIV tests conducted among key populations at higher risk to HIV, and effectively counselled.

3.3.2.2 Prevention of Mother to Child Transmission of HIV

Total 60482 ANC women were screened for HIV from which 14 were identified as HIV positive and enrolled in HIV treatment in FY 2075/76. The above figure shows that there are still too many HIV positive cases are missing in the community which need to be identified and enrolled in ART by improving quality and accessibility of program activities.

Distrcts	Testing under PMTCT program					
	FY 073/074		074/075		075/076	
	Tested	Positive	Tested	Positive	Tested	Positive
BARA	4625	0	4914	0	5940	1
DHANUSA	10412	6	10873	0	15565	0
MAHOTTARI	1664	1	3357	5	2239	1
PARSA	2647	4	2341	3	3988	5
RAUTAHAT	1555	0	1353	0	2461	0
SAPTARI	3437	0	6871	2	13533	1
SARLAHI	1439	3	2129	2	5076	5
SIRAHA	6945	3	13276	0	11680	1
Province Total	**32724**	**17**	**45114**	**12**	**60482**	**14**

3.3.2.3 Anti-Retroviral Therapy (ART)

The national antiretroviral treatment program was started in Nepal in February 2004 from Teku Hospital in central development region. At present 3 or more ARV drugs are recommended for the treatment of people with HIV infection. The main goals of the Antiretroviral Therapy are (a) Maximal and durable suppression of viral load (2) Restoration and/or preservation of immunologic function (3) Reduction of HIV related morbidity and mortality (4) Improvement of quality of life of HIV infected

persons (5) Prevention of Mother to Child Transmission (PMTCT) (6) Post Exposure Prophylaxis (PEP). The province government is providing free of cost ART service for all those in need under the National ART guideline.

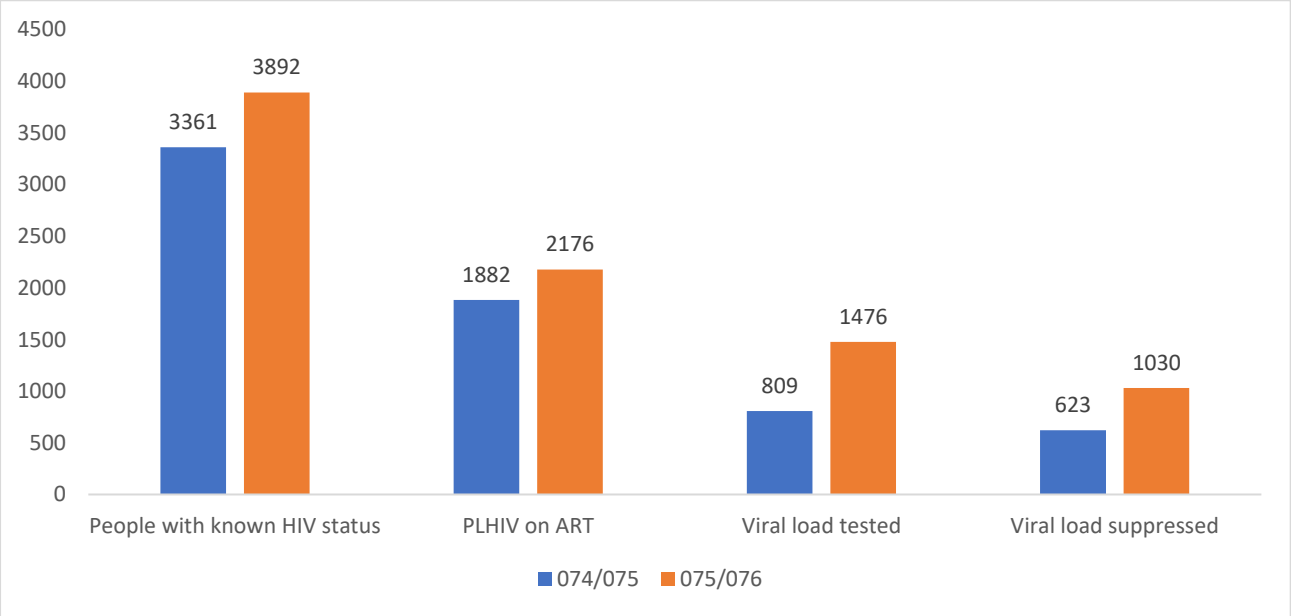
Number of Anti-Retroviral Therapy (ART) centre is in increasing trend (Table 37). The number of person receiving ART is also increasing in comparison to the last fiscal year.

Table 37: ART centres and number of person receiving ARV

Districts	***PLHIV on ART***		
	073/074	**074/075**	**075/076**
SAPTARI	88	104	114
SIRAHA	62	129	188
DHANUSA	497	409	479
MAHOTTARI	53	200	236
SARLAHI	114	192	231
RAUTAHAT	80	112	155
BARA	11	21	33
PARSA	523	622	740
PROVINCE TOTAL	**1428**	**1789**	**2176**

Till the end of FY 2075/76, cumulative 2176 PLHIVs were receiving Antiretroviral therapy (ART) form 08 ART centres of Prov02 which was only 1789 in FY 2074/75. Gradual increasement has been observed in the ART utilization.

3.3.2.4 Treatment Cascade:



The above figure shows that the number of HIV positive case identification and enrolment for ART service is in increasing trend in Province 02. It means, there might be still many cases missing in the community which need to be identified and link with treatment by improving quality and accessibility of services. The variance between case identification and enrolment in ART is still seems very high and it is mostly due to stigma and discrimination in the community. By the end of FY 2075/76, only 56% of PLHIVs got enrolled in ART out of total PLHIVs who know their status. Out of total enrolled, only 68% of PLHIVs has been tested for Viral Load in FY 2075/76.

3.3.3 Issues and Recommendations

Issues	Recommendations	Responsibility
Poor case finding, case management and retention for treatment (Difficulty to meet 90-90-90 target as per national strategy)	Increase community mobilization activities	Palikas/Health offices/ PHD/MOSD /EDPs with the support of NCASC
Irregular CB-PMTCT service at HF level	Regularization/re-activation of PMTCT services in all HFs	Palikas/Health offices/ PHD/MOSD
Inadequate delivery service for HIV positive mothers in Prov02	Manage delivery service for HIV positive mothers	PHD/MOSD
Irregular and improper recording and reporting of PMTCT services in HMIS system at HFs level	Establish proper and regular recording and reporting from all HFs	Palikas/Health offices/ PHD/MOSD
Delay or no data entry at Hospitals and Palikas	Establish proper and regular data entry system at Palika level	Palikas, Hospitals and PHD
Irregular and inadequate lab service especially for CD4 count and VL test	Manage and ensure regular and adequate lab services especially for CD4 and VL test	PHD/MOSD/EDPs with the support of NCASC
Inadequate no. of HTC and ART sites in the districts	Expansion of the services sites based on need assessment and geographical areas of key at risk population	Palikas/Health offices/ PHD/MOSD /EDPs with the support of NCASC
Insufficient and delay supply of Health commodities (STI drug, test kits, condoms, lubricants and IEC materials, re-agent for CD4 count) in SDPs.	Enough supply of health commodities as per the demand and timely in the SDPs.	Palikas/Health offices/ PHD/MOSD /EDPs with the support of NCASC

CURATIVE SERVICES

4.1 Background:

The provincial government, province no. 2 is committed to improve the health status of rural and urban people by delivering high-quality health services. In December 2006 the government of Nepal began providing essential health care services (emergency and inpatient services) free of charge to destitute, poor, disabled, senior citizens, FCHVs, victims of gender violence and others in up to 25-bed district hospitals and PHCCs and for all citizens at health posts in October 2007. The Constitution of Nepal has guaranteed the basic health services emergency services as the fundamental human right of the people and province government is in the line of implementing those rights. The overall objective of the province government on curative services is to reduce morbidity, mortality by ensuring the early diagnosis of diseases and providing appropriate and prompt treatment.

These are two central hospitals, one is Narayani Hospitals and another is Gajendra Narayan Hospitals. Now, Janakpur is the only one provincial Hospital in province no. 2. Rest of ten governmental districts hospitals; these are Bhardah Hospital, Lahan Hospital, Siraha Hospital, Jaleshwor Hospital, Bardibas Hospital, Malangwa Hospital, Chandranigahapur Hospital, Gaur Hospital, Kalaiya Hospital and Pokhariya Hospital.

There are two private medical colleges such as National Medical College, Birganj and Janaki Medical College, Ramdiya, Dhanusha. In addition, two Eye Hospitals like Janaki Eye Hospital, Janakpur and Sagarmatha Eye Hospital, Lahan.

4.2 Major Activities and Achievements in the fiscal year 2075/76

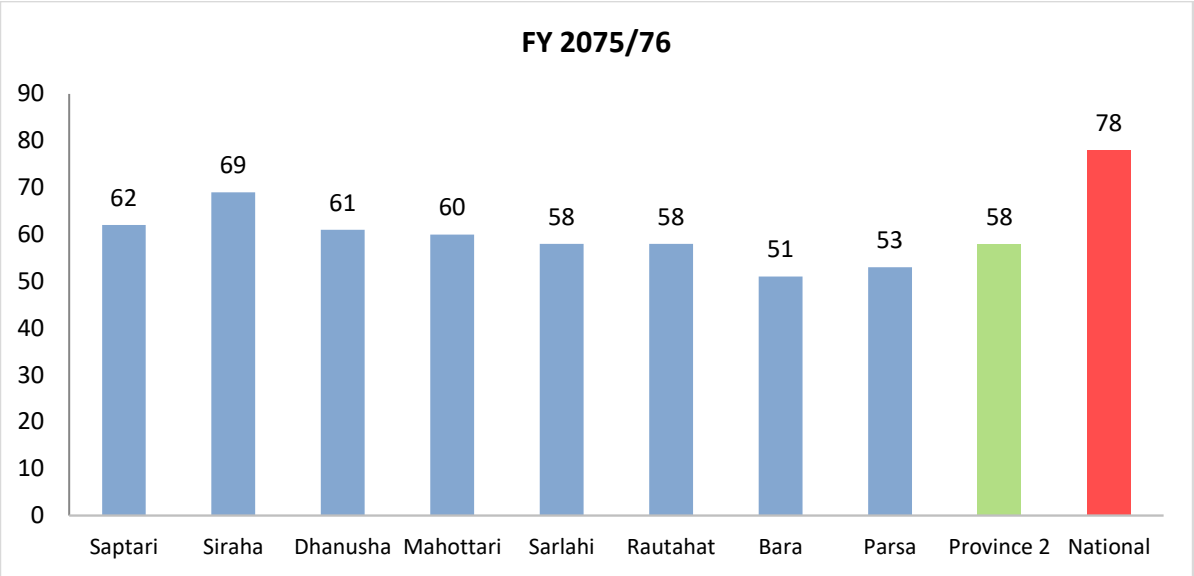
Curative health services were provided at all health facilities including outpatient, emergency and inpatient care and free health services. Inpatient services were provided at all levels of hospitals including INGO and NGO run hospitals, private medical college hospitals, nursing homes and private hospitals. Medical camps were also organized to reach the unreached population. Thirteen government led hospitals are delivering curative health services in addition to 2 private medical colleges and many private hospitals, polyclinics, and clinics. All government led hospitals had reported 97 percent in the fiscal year 2075/76.

4.3 Total OPD new Visits

It is the proportion of total number of OPD new visits to the total population of the catchment area. In the fiscal year 2075 /76, the average number of visits (in Health posts, PHCCs, District Hospital and other hospitals) were more than 1.5 times the total population of the districts which could be due to the referrals from adjacent districts. Overall, the percentage of new OPD visits in provincial level is almost less to the national figure.

At province level, OPD new visits as percentage of total population was 47 % in FY 2073/74, which was slightly decreased to 45 % in 2074/75 and again it was gradually increased to 58 % during fiscal year 2075/76.

Figure 50: Total new OPD Visits by Districts in FY 2075/76



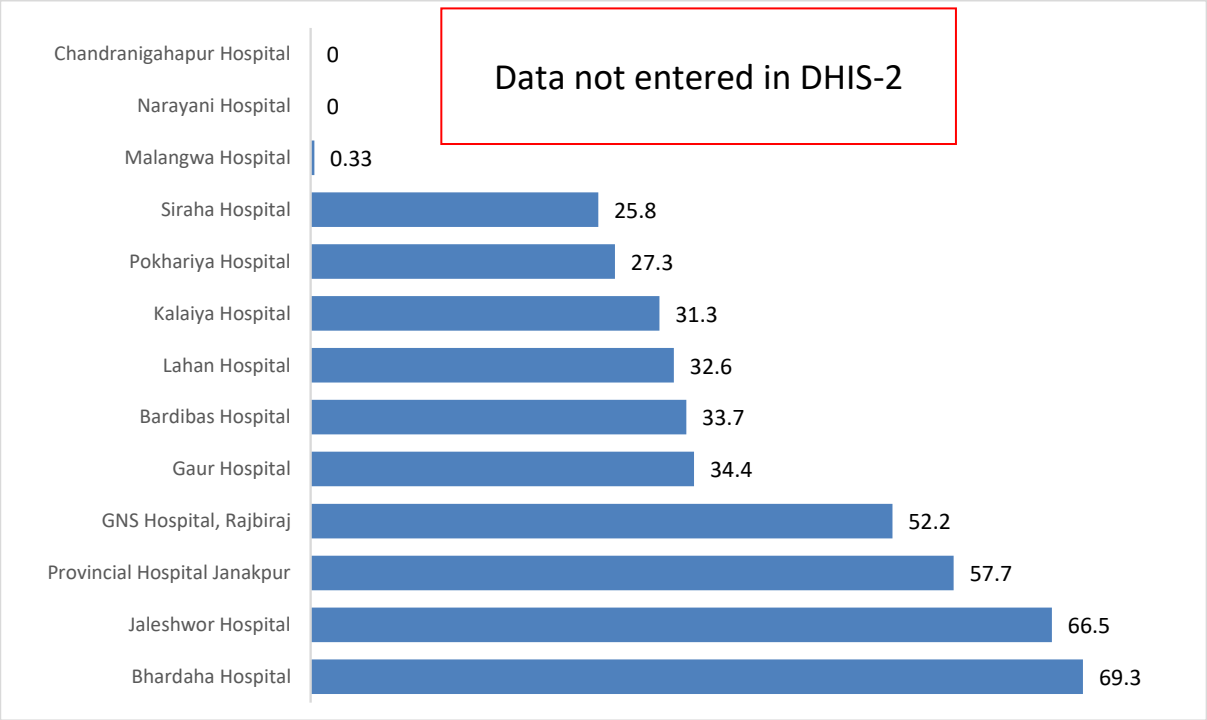
4.4 Inpatient services:

Inpatient services are provided through inpatient departments at public and non-public hospitals. The inpatient services indicators need to be interpreted with caution because few non-public hospitals had not reported for the all 12 months of year and among those which reported round the year few had reported incomplete.

4.5 Bed Occupancy Rate (BOR):

Bed Occupancy rate is the total no. inpatient days stay in a hospital out of total no. of bed days (365 *total no. of beds available). It shows how the hospital's inpatient department is busy and whether the hospital is crowded or not.

Figure 51: Bed occupancy rate of hospitals in Province 2, FY 2075/76



The occupancy rate is a measure of utilization of the available bed capacity. It indicates the percentage of beds occupied by patients in a defined period of time, usually a year. It is computed using the following formula:

BOR= (Inpatient days)/ (Bed days) ×100

Where,

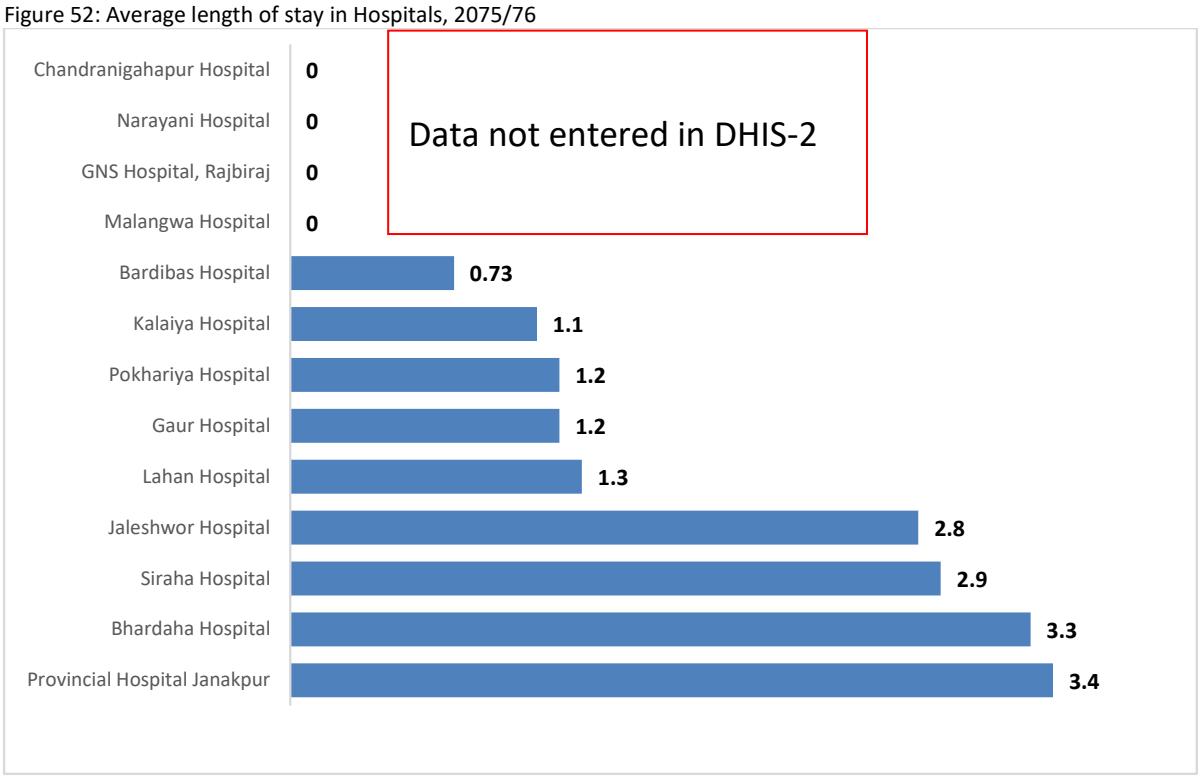
Inpatient days = admissions × Average length of stay (ALS), and bed days in the year = number of beds × 365 Though, there is no such standard benchmark for the bed occupancy rate, some people argue that 85 % occupancy is appropriate and well manageable and some also believe that 75 % is good for quality of services and optimum use of resources in the hospital. Narayani Hospital and Chandranigahapur Hospital had reported uncompleted.

4.6 Average Length of Stay (ALS):

This measure refers to the average number of days that a patient stays in a hospital. It is calculated using the formula: ALOS= Total Inpatient days/Total no. of admissions (discharges).

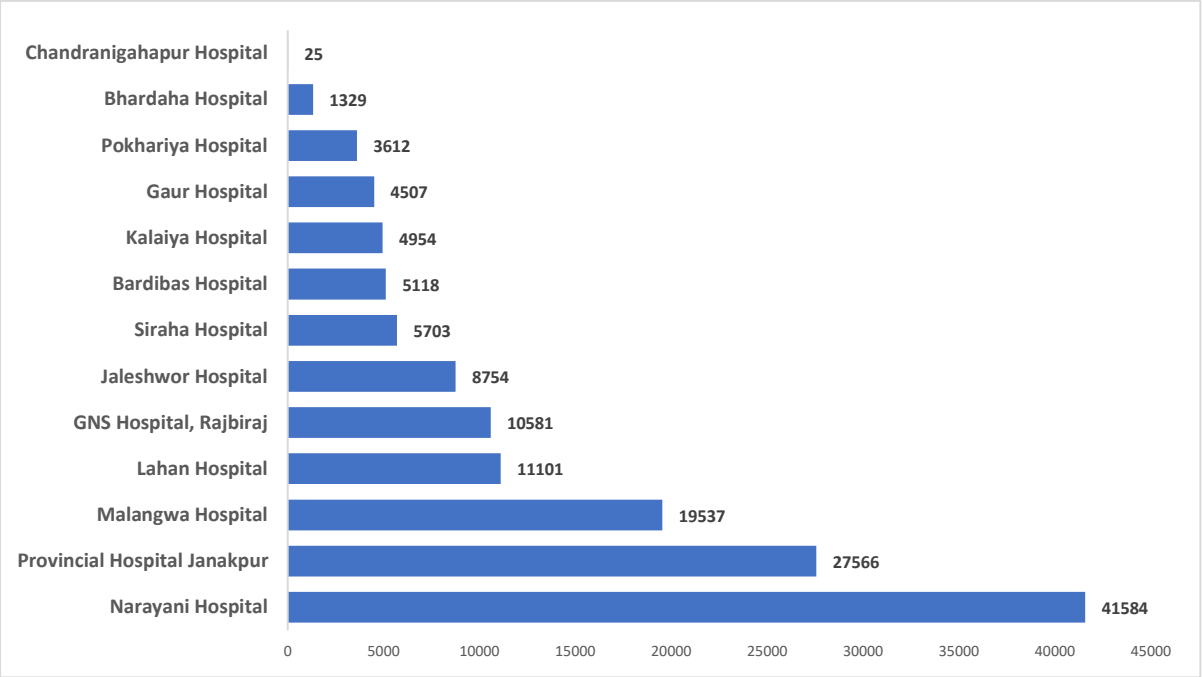
The average length of stay in hospital was longest in Janakpur Provincial Hospital as an inpatient spends 3.4 days in average before get discharged. The average length of stay tends to be longer in tertiary level hospitals because of referred complicated cases might need longer treatment. However, the figure below shows that the length of stay was lowest in Bardibas hospital which could be due to the poor recording and reporting of the hospitals. In four hospitals had reporting uncompleted such as Narayani hospital, Gajendra Narayan Hospital, Malangwa district hospital and Chandranigahapur hospital.

Figure 52: Average length of stay in Hospitals, 2075/76



4.7 Total number of emergency services:

Figure 53: Total emergency services by hospitals in 2075/76



Tertiary hospitals were more likely to receive more emergency cases. Moreover, strategic location, large catchment area, perceived good quality of services, lower cost, etc. can increase the no. of emergency services. Almost 41 thousand people were served from emergency in Narayani Hospital, Parsa. Chandranigahpur Hospital, Rautahat was found to be serving fewer than 25 patients in emergency in a FY 2075/76.

4.8 Delivery Services:

Institutional delivery is increasing rapidly in last few years with raising awareness of importance of delivery in health institutions with skilled attendants. *Ama suraksha karyakram* has also contributed significantly in increment in institutional delivery. WHO suggests that, 15 percent of total delivery can be complicated and 5 percent cases might need cesarean section, however CS rate has raised these years and the reason could be increment in elective CS. The following table gives the details of total delivery and CS rate in hospitals of province no. 2.

Table 38: Total number of delivery services by hospitals in 2074/75 within the province

Name of Hospitals	***Total delivery***	***Total no. of Caesarean section***	***Percentage of CS among total delivery***
Janakpur Provincial Hospital, Dhanusha	11119	2176	19.6
Chandranigahapur Hospital, Rautahat	1101	51	4.6
Narayani Hospital, Parsa	7889	1495	19
Gajendra Narayan Hospital, Saptari	3591	360	10
Malangwa District Hospital, Sarlahi	1501	2	0.13
Bardibas Hospital, Mohattari	823	0	0
kalaiya District Hospital, Bara	3867	112	2.9
Pokhariya Hospital, Parsa	951	0	0
Gaur Hospital, Rautahat	1784	51	2.9
Lahan Hospital, Siraha	3660	202	5.5

District Hospital, Jaleshwor	1382	151	10.9
District Hospital, Siraha	392	0	0
Bhardaha Hospital, Saptari	350	8	2.3
Total Province	38410	4608	11.9

Top ten morbidities:

The top ten morbidities in OPD visits in FY 2075/76 were as below.

Table 39: Top ten morbidities, FY 2075/76

S.No.	***Name of Disease/Morbidity***	***Number of cases***
1	Water/Food Borne - Intestinal Worms Cases	2,18,019
2	Other Diseases and Injuries - PUO	2,11,905
3	Other Diseases and Injuries - Gastritis (APD)	1,96,177
4	Surgical Problems - Not mentioned Above and Other	1,80,499
5	Scabies	1,73,962
6	URTI	1,66,076
7	Other Diseases and Injuries - Headache	1,56,378
8	Infectious Diarrhoea	1,51,422
9	LRTI	1,42,022
10	Fungal Infection	1,34,243

SUPPORTING PROGRAM

5.1 Health Training

5.1.1 Background

Training is a part of Human Resource Development (HRD) and it is a most priority area for quality health services delivery. The integration of public health program has introduced systematic training process in 1974, with the aim to train all the health personal on integrated health service that were brought from vertical health projects. The revision of the health services structure in 1993 brought the institutional leadership in the area of human resource training on health sector. In Province, one provincial training centre, eight district level training centres have been established and started to provide training for health personnel.

Goal: The overall goal of training program in health sector is to produce/prepare efficient health service providers by means of training to contribute delivering quality health services towards attainment of the highest level of health status of Nepalese people.

Objectives

In order to enhance the overall capabilities of health workers for delivering the quality health services, the training centres fulfil the following objectives:

- Assess training requirements of health workers and develop the appropriate future plan.
- Provide the different kind of skill-based training to health workers at different level.
- Develop and strengthen the health training system
- Develop, suggest and refine teaching and learning materials
- Produce quality trainers to facilitate training at different level.
- Support in organizing, implementing and evaluating the training programs
- Coordinate with all stakeholders in training program for delivering the quality of services.
- Design, Suggest and conduct operational studies to improve training efficiency and effectiveness.

5.1.2 Analysis of Achievement

Provincial Health Training Centre, Pathalaiya, Bara is fully responsible for basic training, pre-service training and in-service training of primary health care workers of 8 districts of this province. During the year 2075/76 the target versus achievement of training programs is given below in the Table 40.

Table 40: Target versus Achievement of PHD activities in 2075/76

SN	Programs/Activities	Unit	Target	Achievement	Achievement %
1	SBA training (3 Batch)	Person	30	30	100
2	MLP training (2 months)	Person	16	16	100
3	COFP/ R.H. Counseling Training [For Health workers; Duration = 8 days]	Person	24	24	100
4	SRH training [ToT]	Person	15	15	100
5	SRH Basic training	Person	30	30	100
6	IUCD training	Person	8	8	100

Source: IEC section, PHD

5.2 Health Education, Information and Communication

5.2.1 Background

Health Education, Information and Communication (HEIC) is a package of planned interventions with the combination of educational, informational and motivational processes. The main aim is achieving measurable increase in health knowledge and changing the attitudes and behaviour of specific audiences. Moreover, it is responsible for developing, producing, and disseminating messages to promote and support specific health-related programmes and services in an integrated manner. For this purpose, health education, information and communication programmes have been in all districts in this province. The HEIC units in PHD and Health Offices work to meet the increasing demand for HEIC by implementing HEIC activities, utilizing various media according to the needs of the community. Local media and languages are used so that people can understand the health messages clearly in their local context.

Goal: The overall goal of this supporting activity is improving the health status of people by changing their knowledge, attitude and practices of each individual, group and community.

Objectives

The main objective of HEIC is to raise the health awareness of the people as a means to promote improved health status and to prevent disease through the efforts of the people themselves and through full utilization of available resources of curative, rehabilitative, preventive and promotive health services.

The specific objectives of the programs are:

- to increase awareness and knowledge of the people on health issues
- to increase positive attitude towards health care
- to increase healthy behaviour
- to increase participation of people in health intervention at all level of health services
- to increase access to new information and technology on health and programs for people

5.2.2 Analysis of Achievement

The achievement of HEIC related activities at provincial level was satisfactory. The HEIC activities carried out by the districts were achieved 100% during FY 2075/76. The efficacy and impact of the HEIC activities need to be monitored from central and regional offices.

Table 41: Provincial Achievement of HEIC activities in FY 2075/76

S.N	*Activities*	*Unit*	*Target*	*Achievement*	*Physical Achievement%*
1	Mero Barsa	Time	1	1	100

Source: IEC section, PHD

5.2.3 Issues and Recommendations

Issues	Recommendations	Responsibility
Lack of proper use of IEC materials for community level	Strengthening supervision and monitoring	NHEICC/ PHD/HO/Palika
Late distribution of IEC materials from District to Palika to community level.	Timely distribution of IEC materials	NHEICC/HO/Palika

5.3 Administrative Management

5.3.1 Background

The Administration Section of PHD takes the responsibility of organising day-to-day internal administrative and personnel management. This section is the focal point for the general administration and human resource management of non-gazetted posts for all Hospitals (including Federal), Provincial Health Directorate, Health Offices, Primary Health Care and Health Posts within the province under the Ministry of Health and Population/MoSD and Local level.

Objectives

The main objective: To achieve effectiveness in right staffing at the right place for health service delivery system:

- to recruit, post and promote non-gazetted staffs
- To transfer, recruit and manage all the posts according to the National Health Policy.
- To deploy health staff to the sanctioned posts in all health institutions with in province according to the organogram
- To manage human resources at the different levels of non-gazetted positions

5.3.2 Analysis of Achievement

A: Health Service Delivery Centre

The health service delivery points throughout the province are shown in the Table 42. In total, there were 13 Hospitals including Federal level hospitals, 33 PHC and 748 HPs in this province in FY 2075/76. Similarly, total 2358 PHC/ORCs, 3384 EPI Clinics and 156 birthing centres were functioning at periphery level. Besides these institutions, there are altogether 7622 FCHVs delivering basic health services on their community.

Table 42: District wise Hospital, PHCC, HP, PHC/ORC, EPI Clinics and FCHVs FY 2075/76

SN	District	Total No. of Hospital	Total No. of PHC	Total No. of Health Post	Total No. of PHC/ORC	Total No. of EPI clinics	Total No. of FCHV	Total No. of Birthing Centre	Total No. of Private Health Institution
1	Saptari	2	4	111	406	460	1016	24	8
2	Siraha	2	4	104	251	432	1047	23	62
3	Dhanusha	1	5	98	322	486	866	14	37
4	Mahottari	2	4	76	273	359	846	13	13
5	Sarlahi	1	5	94	226	344	1299	25	15
6	Rautahat	2	3	91	333	422	909	22	10
7	Bara	1	5	96	277	493	1005	13	30
8	Parsa	2	3	78	270	388	734	22	38
	Total	**13**	**33**	**748**	**2358**	**3384**	**7622**	**156**	**213**

Source: FCHVs (DHIS2)

B: Human Resource Situation District wise in FY 2075/76

Saptari District:

Categories	Sanctioned post (Number)	Fulfilled		Filled in contract (Karar)
		Number	%	
Medical doctors	7	5	71	6
Public Health Administrator/ Officer	1	0	0	0
District Supervisors	3	2	67	0
Medical Recorder	0	0	0	0
Paramedics (HA/Sr. AHW/AHW)	464	450	97	0

Nursing staff	242	233	96	0
Lab staff	1	1	100	0
Administrative Staff	1	1	100	0
Others Ka.sa.	2	2	100	2
Total	**720**	**694**	**96.39**	**8**

Siraha District:

Categories	***Sanctioned post (Number)***	***Fulfilled***		***Filled in contract (Karar)***
		Number	**%**	
Public Health Administrator/ Officer	1	0	0	
Public Health Officer	1	1	100	
District Supervisors	3	2	66.6	
Malaria Inspector	1	1	100	
Cold Chain	1	1	100	
Lab staff	1	1	100	
Account Officer	1	0	0	
Public Health Nurse	1	0	0	
Statistics Officer	1	0	0	
Administrative Officer	1	0	0	
Sanctioned Ka.Sa.	2	2	100	
Light Wt. Driver	1	1	100	
Swipper	0	0	0	1
Total	**15**	**9**	**60**	**1**

Dhanusha District:

Categories	***Sanctioned post (Number)***	***Fulfilled***		***Filled in contract (Karar)***
		Number	**%**	
Medical doctors	5	5	100	
Public Health Administrator/ Officer	1	1	100	
District Supervisors	3	2	100	
Paramedics (HA/Sr. AHW/AHW)	309	315	100	
Nursing staff	5	5	100	
Lab staff	6	6	100	
Administrative Staff	1	1	100	
Others	2	2	100	
Total	**332**	**337**	**100**	

Mahottari District:

Categories	***Sanctioned post (Number)***	***Fulfilled***		***Filled in contract (Karar)***
		Number	**%**	
MO	5/4	3/3	60	
Public Health Administrator/ Officer/Inspector	1	0	0	-
Supervisors	3+1 (PHN)	3+1	100	-
Statistical officer	1	1	100	-
Paramedics (HA/Sr. AHW/AHW)	80/229	80/229	100	-

Nursing staff/ANM	15/161	12 /161	80/100	-
Lab staff	7	7	100	
Administrative Staff	4	3	75	
Others (Computer Operator)	1	-	-	

Sarlahi District:

Categories	***Sanctioned post (Number)***	***Fulfilled***		***Filled in contract (Karar)***
		Number	**%**	
Medical doctors	7	5	71	
Public Health Administrator/ Officer	1	0		
District Supervisors	3	2	67	
Paramedics (HA/Sr. AHW/AHW)	396	363	92	
Nursing staff	203	196	94	
Lab staff	7	7	100	
Administrative Staff	1	1	100	
Others	2	2	100	
Total	**620**	**576**	**92.9**	

Rautahat District:

Categories	***Sanctioned post (Number)***	***Fulfilled***		***Filled in contract (Karar)***	***Recruited using local and other resources***
		Number	**%**		
Medical doctors	18	6	33	4	0
PHA/PHO	1	0	0	1	0
District Supervisors	8	14	100	0	
Medical Recorder	1	0	0		
Paramedics (HA/Sr. AHW/ AHW)	421	391	93	63	2 (HDC)
Nursing staff	234	205	87.6	49	3 (HDC)
Lab staff	12	10	83	1	
Administrative Staff	4	3	95		
Others	2	2	100		
Total	**707**	**631**	**89.25**	**118**	

Bara District:

Categories	***Sanctioned post (Number)***	***Fulfilled***		***Filled in contract (Karar)***
		Number	**%**	
Medical Doctors	5	5	100	5
Public Health Administrator	1	1	100	
District Supervisors	16(4)	16(3)	100	
Medical Recorder	0		0	
HA/Sr AHW	104	104	100	20
Staff Nurse	5	3	60	3
Radiographer/Dark room Assistant				
Lab technician/Assistant	8	8	100	3
Total				

Parsa District:

Categories	*Sanctioned post (Number)*	*Fulfilled*		*Filled in contract (Karar)*
		Number	**%**	
Medical doctors	6	3	50	
Public Health Administrator/ Officer	1	1	100	
District Supervisors	5	3	60	
Paramedics (HA/Sr. AHW/AHW)	335	276	82	
Nursing staff	180	158	87	
Lab staff	4	4	100	
Administrative Staff	0	0	0	
Others	0	0	0	
Total	**531**	**445**	**83**	

Source: PHD, Administration Section

6.3.3 Name List of PHD Staffs

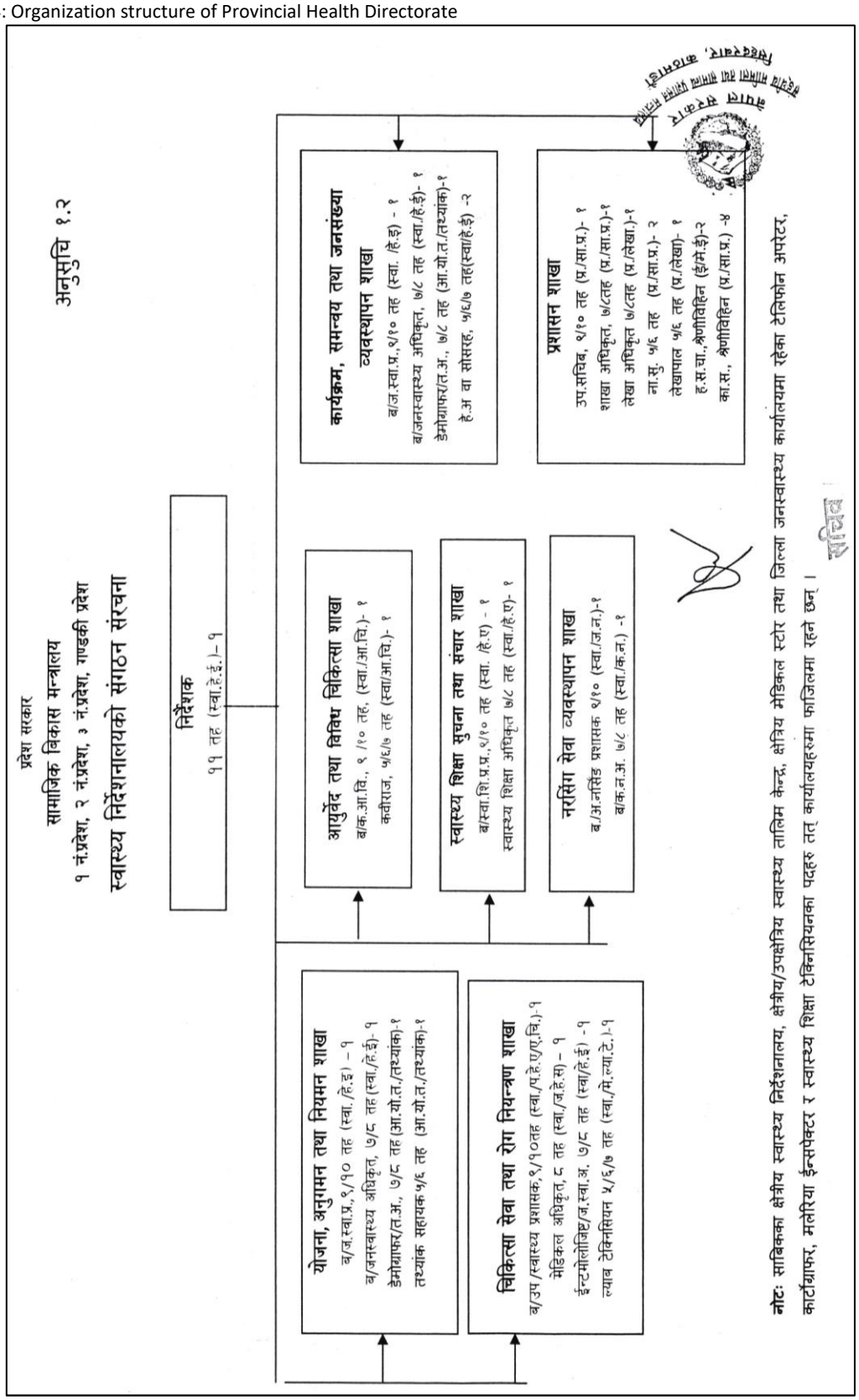
S.N.	Designation	Name
1	Provincial Director	Mr. Hari Chandra Sah
2	Sr.PHA	Mr.Vijay Kumar Jha
3	Sr. Health Administrator	Dr. Mukti Narayan Sah
4	Sr. Health Education Officer	Mr. Dev Kant Jha
5	MD (Community Medicine)	Dr. Kamlesh Yadav
6	Medical Officer	Dr. Sanjay Kumar Yadav
7	Statistical Officer	Mr. Suresh Yadav
8	Statistical Officer	Mr. Lal BabuYadav
9	Statistical Officer	Mr. Saroj Yadav
10	Account Officer	Mr. Gopal Oli
11	Admin. Officer	Mr. Mithlesh Mahato
12	TB/Leprosy Officer	Mr. Rajbir Yadav
13	Immunization Officer	Mr. Bhola Pandit
14	PHO (Scholarship)	Mr. Bipin Yadav
15	Lab. Tech.	Mr. Phulendra Yadav
16	PHI	Mr. Binod Yadav
17	Lab. Tech.	Mr. Karamsil Pd. Gop
18	Kabiraj	Mr. Dipendra Kumar Yadav
19	Na. Su	Mr. Arbindar Das
20	Computer Operator (contract)	Mr. Gangadhar Dev

21	Office Assistant	Mr. Raj Narayan Mahato
22	Office Assistant	Mr. Bhola Yadav
23	Driver	Mr. Ram Bhajan Yadav
24	Driver (contract)	Mr. Binod Mandal
25	Ka. Sa (contract)	Mr. Suraydev Yadav
26	Ka. Sa (contract)	Mr. Rupesh Yadav
27	Ka. Sa (contract)	Mr. Manisha Jha
28	Helper (contract)	Mr. Mukesh Master

Source: PHD, Administration Section

5.3.3 Organization Structure of PHD

Figure 54: Organization structure of Provincial Health Directorate



Source: DoHS, Management Division, 2075

5.3.4 Issues and Recommendations

Issues	Recommendations	Responsibility
Not clear understanding of different provision on padnaam, upgrade and fulfillment.	Orientation and meeting with all administration staffs should be organized.	MoHP/DoHS/PHD
Vacant vital posts	Vacant post should be fulfilled immediately	MoHP/DoHS/MoSD/PHD
Different provision on the same issue (e.g. Nepal health act and governance make different provision for the same issue)	Revising Act/Rule-Regulation/Policy to avoid such contradiction.	MoHP/DoHS/MoSD/PHD
Mismatch posting	Proper posting should be done	MoSD/PHD
Capacity of HRH	Capacity enhancement training	MoSD/PHD
Incomplete samayojan	Samayojan should be completed	MoSD/PHD

5.5 Management Activities

5.5.1 Background

For effective implementation of health programme, information-based management plays an important role for effective delivery of health services through health institution. Considering this factor, Ministry of Social Development, PHD has introduced the management related activities in District and local level. Performance review at Province and district level, DHIS2 training and integrated supervision are the activities listed for this programme. Statistics/HMIS section of PHD plays as a focal unit to coordinate and conduct these activities between the district and local level.

Objectives

- To facilitate Health Offices to prepare annual work plans
- To collect progress reports from local health service delivery points of HP, PHC, and Hospitals through Municipality/Rural Municipality.
- Monitor programme performance by providing the periodical feedback in term of achievement, coverage, continuity and quality of services
- Provide the information that can be used to improve quality of health services and management capacity to all level of health institutions
- To provide feedback of the implemented programmers to Districts regarding findings from monitoring, supervision and evaluation;
- Help to generate the quality data in Municipality/Rural Municipality.
- To prepare necessary action, co-ordinate and support for monthly, bi-monthly and trimester performance review meeting;
- To develop a mechanism for quality control of health services in the Province.

5.5.2 Analysis of Achievement

The achievement of management related activities in this Province have been shown in the Table 43. There are 4 major activities in this year 2075/76.

Table 43: Target Vs Achievement of Management Activities FY 2075/76

S.N	*Name of Activities*	*Unit*	*Target*	*Physical Achievement (No)*	*Achievement %*
1	Provincial level annual review	Time	1	1	100
2	DHIS2 training	Time	1	1	100
3	Capacity building training for Health coordinators	Time	1	1	100
4	Capacity building training for Hospital Management staffs	Time	1	1	100
Total					**100**

5.5.3 Issues and Recommendations

Issues	Recommendations	Responsibility
Problem in qualitative Recording and reporting	Regulatory law should be formed Data quality workshop should be conducted	Province/Local level
Monthly review with district office and local levels	Should be done properly Monthly supervision, monitoring and data verification of local health facilities	Health Office/Local level
Quarterly review meeting with Province level	Quarterly review meeting should be done by Province level	PHD

Inadequate/ timely supply of HMIS tools	Adequate numbers should be printed, and timely supply should be assured by giving authorization to PHD and Districts for printing that tools.	Provincial Logistics Division/MD
Inadequate budget of HMIS tools	Adequate budget should be allocated	MoSD/MD
Inadequate reporting of data in DHIS 2	Integration of all data of TB, HIV, Malaria etc. in DHIS2	PHD

5.6 Epidemic Investigation and Response

5.6.1 Background

Nepal is prone to multi disasters due to its diverse and fragile geographical structure, variable climatic conditions, active tectonic process, unplanned human settlements, inadequate resource allocation and initiatives for disaster preparedness activities. According assessment made based on Global Climate Risk Index, Nepal lies at 4th rank in terms of climate risk at global level indicating higher vulnerability for human and economic losses. Furthermore, Nepal ranks 11th in terms of earthquake vulnerability and 20th for multi hazard countries in the world. Thus, Nepal is highly prone to epidemics, earthquake, landslide, windstorm, cold waves, and floods causing huge economic losses and human fatalities. Province two is highly prone to flood due to its plain geography and fragile coping mechanism subsequently resulting in outbreaks of water borne and vector borne diseases including snakebites. Moreover, cold waves, outbreaks of diseases like dengue, Kala azar, measles, increasing road traffic accidents are the constant challenges for health sector to response in province two.

5.6.2 Events

For the first time in Nepal, tornado occurred in Bara and Parsa districts causing damage to more than 2600 households, more than 1100 injuries and 28 deaths. Similarly, Kala Azar outbreak was observed in Sarlahi district with human fatalities, dengue outbreak happened in Sarlahi, Mahottari districts, measles and diarrheal outbreaks were also observed in few districts of province two despite government commitment to contain the possible outbreaks.

5.6.3Responses

Ministry of Social development, province health directorate are constantly engaged in preparedness, responses and recovery actions for damage and disruption caused by various epidemics and outbreaks to protect and promote the health and wellbeing of the most vulnerable and marginalized population. Province rapid response team (RRT) was active and functional to address the epidemics and outbreaks with prompt actions at province level. In addition, district and local level rapid response teams were made functional. EWARs was strengthened and functional at all the sentinel sites. Different cluster mechanisms like health and nutrition, protection, WASH clusters were formed and activated in active support and involvement of UN agencies and other development partners. Furthermore, UN agencies like WHO, UNICEF, UNFPA and other development partners provided relief materials to the affected population and supported province and local governments to resume health services during the disaster period.

Despite efforts of province, local government and development partners, health sector is consistently facing varied challenges during humanitarian situation for the delivery of health care services to the affected people with full potential. So, there is urgent need to formulate health sector emergency response plan at province level, strengthen coordination among the local and province government, enhance the inter-ministerial coordination and collaboration to address health emergencies, and make health system resilient to cope with possible epidemics, outbreaks and humanitarian crisis.

ANNUAL HEALTH REVIEW AND PLANNING WORKSHOP FY 2075/76

Background

The review meeting was inaugurated by Mr Nawal Kishor Shah, Minister for MoSD, province 2 and conducted from November 29-30, 2019 for two days in Hotel Sita Sharan, Janakpurdham, Dhanusha. The Participants in the review and planning workshop were representatives from Federal/province ministry, departments, centers, DoHS/HoA/DDA, DHO/DPHO and representatives from Hospitals, RMS/medical colleges, EDPs and media. Altogether 156 (male -145 and female 11) were participated in the review meeting. Please refer Annex-1 for detail schedule of the program.

After the remarks by chief guest and other guests, District presentations (Saptari, Siraha, Dhanusha, Mahottari, Sarlahi, Rautahat, Bara and Parsa), Hospital presentations and Ayurvedic centres presentaions were done and discussions carried. The panel discussions (2 panels) on federal issues, district issues and way forward, was done followed by EDPs consolidated presentation, joint planning and way forward in group.

Activities:

Day 1: November 29, 2019:

The review meeting was inaugurated by Mr Nawal Kishor Shah, Minister for MoSD, province 2 and conducted from November 29-30, 2019 for two days in Hotel Sita Sharan, Janakpurdham, Dhanusha. Chiefs from all Health Offices, federal and provincial hospitals, were participated and presented their achievement in the review meeting. The meeting was chaired by Mr Harish Chandra Shah, Director-PHD.

Similarly, cheif / representatives from DoHS, MD, NTCC, NHTC, FWD and EDPs were also participated in the review meeting.

Day 2: November 30, 2019:

The PARM was continued with the presentation from hospital chief and national divisions and centres. The meeting had also group work to improve the HMIS data in province 2. Finally, the meeting was concluded with a way forward to improve the data quality, timeliness and accuracy in province 2.

Issues and Recommendation

Identification of problems or issues and action to resolve those issues is a continuous process of system improvement. In the newer context of federal system, there are many issues, the province is facing and tackling. Annual health review was organized to review the progress, discuss the pertinent issues with multiple stakeholders like federal government especially ministry of health and population, external development partners, hospitals, district public health offices and private hospitals

Many issues were raised during the two-day review program with few innovative actions taken in different districts to improve the health system and health status of the people. Some program specific key issues raised, recommendations made, and responsible stakeholders identified and presented in respective program chapter, while some general issues, recommendations and responsible stakeholders are summarized in the below table.

Issues	Way Forward
Immunization	
• Target population not compatible with community population • Reduction of coverage of antigens with increase of child age to second year of life (Poor MR Coverage) • Irregular commodities Immunization Supply Chain • Poor cold chain management and inadequate stock management • Inadequate cold chain equipment including vaccine carrier	• Conduct Active defaulter tracing • Home visit by health workers and FCHVs as well as repositioning line listing during FID as opportunity for identifying true target • Prepare or update microplanning of immunization • Prepare and use distribution plan for immunization commodities • Establish immunization sub-centre, and distribution center with cold chain equipment
CB-IMNCI	
Poor quality of Recording and reporting of diseases and its treatment regimen	• Quality Onsite coaching, mentoring and monitoring • RDQA and Data verification
Nutrition	
Malnutrition is not considered as a problem	Awareness focusing long term consequences of malnutrition
Growth monitoring is not up to mark	PHC/ORC should be functional. HF should focus on GM
MDD-W, MAD is low	MSNP program should be focused, Annaprashan as a campaign
Recording and reporting is poor	Frequent onsite coaching is needed
Number of OTC centre is minimal	Should be increased with instrument and commodites
Supply of Vit A, RUTF is not according to requirement	Palika should report and should be according to need
Periodic Nutritional assessment is not focused	Facility of Anthropometric measurement
Management and ownership is not felt by Local level	Orientation to be \hfomc, Coordination, orientation with Palika
Safe Motherhood	
• 4th ANC • Institutional Delivery • PNC visit • High neonatal death	• Family Folder • SBA training • Quality Service and timely budget allocation • Counselling by HW/FCHV • Continue MPDSR meeting
Safe Abortion	
Unsafe Abortion	• Make functional of Non-Functional sites • Provider Training (MA/CAC/2nd tri) • Need based site expansion • RH related awareness and Advocacy • Medical monitoring
Family Planning	
• LARC service • Commodities supply	• Increase LARC Trained HR • Regular commodities supply

• Low CPR	• Community awareness and advocacy • Integrated approach
PHC-ORC	
In-active PHC/ORC	• Regular follow up for re-activate • Indicator/target-based performance evaluation
Adolescent sexual and reproductive health	
ASRH services not being regularly and efficiently	• Strengthen and scale up ASRH services • Regular and effective quality services
Demography and RH Research	
Rapid growth of population	• Advocacy to use FP
Female Community Health Volunteer Program	
Inactive and old FCHVs	• Provide golden hand sake to desired old and inactive FCHVs • Revitalize Mother Groups
Disease Control and Disaster Management	
No provision of supervision and monitoring from district to Palika regarding TB program, low case notification	• Active case finding with expansion of GeneXpert sites and mobilization of van (TB Van) • District level PME workshop on trimester basis with availability of budget for monitoring at palika
Only one lab personal allocated for all preventive program at district level and no proper quality control	• All preventive lab services to be integrated with hospital lab or increase the number of lab personnel in health office
Inadequate and irregular logistic supply for all disease control program	• Timely and regular supply of logisitic need to be done both from province to district and district to local level
Low case finding of HIV cases	• Expansion of ART and HTC sites, Increase community awareness and outreach activities
Poor management of ART sites,	• Strengthening of ART sites with all needful equipment's, furniture's and commodities etc.
Irregular PMTCT service	• Regularization of PMTCT service and supplies
CD4 machine - irregular functioning,	• regularization of CD4 service in the districts
Inadequate reporting of data in DHIS 2	• Integration of all data of TB, HIV, Malaria etc. in DHIS2
Increasing trend of leprosy/LF case notification even though it was under elimination phase	• House to house visit to screen all leprosy/LF cases before declaring elimination
Increasing vector-borne diseases with possibility of outbreak	Integrated vector management • Vector surveillance and preparedness, Destroy vector breeding sites
Outbreak of different communicable disease during disaster	• Preparedness plan of disaster (awareness raising, capacity enhancement etc.) • Storage and supply of logistics (live saving commodities) • Activate and empower local level rapid response team (RRT)

	• Simulation and drill exercise
Hospital services	
Inadequate human resources	• Conduct O&M survey in hospitals • Recruit vacant posts in contract and if still vacant recruit more in contract
Management of departments/units	• Create posts for services like emergency, ICU, NICU
Insufficiency of budget	• Make provision of budget for management of HR for new programs like ICU, NICU, CEONC, SNCU, Cancer Unit
Hospital statistics	• Compulsorily introduce Electronic Medical Recording (EMR) system in hospitals
Waste Management	• Make management of budget and HR who has studied Hospital Management course
Free drugs	• Add more drugs in free drugs list
Blood Bank	• Establish blood banks in all hospitals
Lab Service	• Make arrangement for well-managed laboratories in all hospitals • Make arrangement for sufficient HR in laboratories
Social security, information management, procurement and supply chain management	
Low coverage of health insurance	• Strengthen hospital services • Implement health insurance program according to policy
Reporting from health facilities is not on time	• Implement DHIS 2 and e-LMIS at local level health facilities including private health facilities • Monthly, quarterly and annual review and onsite coaching for data quality improvement
Inadequate capacity for procurement of health logistics	• Capacity development training at province and local level
Duplication and lack of coordination in procurement	• Quantification and forecasting from each level before procurement
No warehouse at province level	• Establish well equipped warehouse at province level under province health logistic management center
Dejunking problems	• Develop guidelines in accordance with national policy to dispose expired drugs and other logistics
Coordination with supporting partners	• Develop mechanism for information sharing from each level of government for logistic management
Gap of information on specific health problems andplan and policy… target scale (0-100)	• Provincial survey for evidence generation
Lack of Act, Rule and regulations, Policy and periodic plan	• Include experienced personnel and formulate provincial policy in prioritized manner
Problem in qualitative Recording and reporting	• Regulatory law should be formed

Inadequate and Delay release of conditional grant and equalization fund	• Release in time and in adequate amount
Monthly review with district office and local levels	• Should be done properly • Monthly supervision, monitoring and data verification of local health facilities
Chain of command and coordination gap between all levels	• Proper policy
Vacant vital posts	• To be fulfilled immediately
Mismatch posting	• Proper posting
Capacity of HRH	• Capacity enhancement training
Incomplete *samayojan*	• To be completed
Ayurveda	
No provision of laboratories in Ayurveda health centres	• Laboratory management
Not enough reach of Ayurvedic discipline of health care	• Conduct door-to-door program
No meeting/yoga halls and pharmacies in Ayurvedic health centres	• Management of a hall and rural pharmacy at Ayurveda Ausadhalaya
No budget for *Panchakarma*	• Make provision of budget for *Panchakarma* management
No updated knowledge in Ayurveda health workers	• Refresher training for Ayurveda health workers
Insufficiency of Ayurvedic medicine	• Management of medicine
No accounts staffs in health centres	• Recruitment of accounts staffs
Cannot track progress of program	• Make provision of program for monitoring and coordination

EXTERNAL DEVELOPMENT PARTNERS

1. WHO

SN	Particular	Information
1	Name of Organization (With Logo & Main Office Address, Website)	World Health Organization Nepal World Health Organization (WHO) UN House, Pulchowk Lalitpur Nepal POB 108 Kathmandu, Nepal
2	Head of the Organization and Contact Information	Dr Jos Vandelaer WHO Representative Tel: +977 1 5523993 GPN: 524400 Fax: +977 1 5527756 Email: @searo.who.int
3	Office Address in the Province (Including Telephone, Website)	Ministry of Social Development (MoSD) Province no 2 Janakpurdham Nepal 9842032462
4	Contact Person for Province Health Program (Name, Position, Mobile/Phone & Email)	**Health System Strengthening** Mr. Ramesh Kumar yadav Province health officer Ministry of Social Development ,Province no 2,Janakpurdham Nepal Cell No 9842032462 Email: ryadav@who.int **IPD** Dr. Shriram Sah (Surveillance Medical Officer) **shahshr@who.int** 9842524949 (Saptari Siraha,Dhanusha Mahottari -Field Office lahan hospital) Dr. Dipendra khatiwada (Surveillance Medical Officer) 9854020199)Sarlahi,Rauthat,bara and Parsa -Field office Janakpur hospital)

5	Organizational Description in brief	The **World Health Organization** (WHO) is a specialized agency of the United Nations that is concerned with international public **health**. It was established on 7 April 1948, and is headquartered in Geneva, Switzerland. ... Its predecessor, the **Health Organization**, was an agency of the League of Nations. The constitution of the WHO has been signed by 61 countries (all 51 member countries and 10 others) on 22 July 1946, with the first meeting of the World Health Assembly finishing on 24 July 1948. It incorporated the Office International d'Hygiène Publique and the League of Nations Health Organization. Since its establishment, it has played a leading role in the eradication of smallpox. Its current priorities include communicable diseases, in particular HIV/AIDS, Ebola, malaria and tuberculosis; the mitigation of the effects of non-communicable diseases such as sexual and reproductive health, development, and aging; nutrition, food security and healthy eating; occupational health; substance abuse; and driving the development of reporting, publications, and networking.
6	Major Health (Thematic Areas) and health sector related programs targeting SDG and UHC	Health System Strengthening Vaccine Preventable Disease Surveillance
7	Program Components	-Technical support on: Develop Provincial policies, strategies, guidelines and plan, Health Information management and documentation Ensure health commodity security, quality health service delivery Health financing for universal health coverage Ensure quality health service delivery HRH planning and management including capacity development of HRH -Technical Assistance: (sustaining Polio free status, NNT Elimination and JE & Rubella Control; achieving Measles and Rubella Elimination and Full Immunization Goals) Introduction of new and underused vaccine (fIPV, Rotavirus vaccine, HPV] Capacity Building: Immunization, VPD surveillance, AEFI investigation and outbreak investigation Supervision-Monitoring of RI program
9	Implementing Partners (INGOs/NGOs/CSOs)	GON

10	Program / Projects (With Duration, Total Budget & Donor)	• Chronic diseases • Environmental health • Health Equity Monitor • Health system Strengthening • HIV/AIDS • IPD • Maternal, neonatal and child health • Noncommunicable diseases • Substance abuse and mental health • Mental health • Violence and injuries
11	Working/Implementation Approach (Redbook, Direct, NGOs)	Redbook, GON

2. UNICEF

SN	Particular	Information
1	Name of Organization (With Logo & Main Office Address, Website)	unicef United Nations Children's Fund Nepal (UNICEF, Nepal) Nepal Country Office, UN House, Pulchowk, Lalitpur, P.O. Box 1187 Kathmandu, Nepal Tel (office): +977 1 5523200 Facsimile: + 977-1-5527280 Email: kathmandu@unicef.org Website: www.unicef.org/Nepal
2	Head of the Organization and Contact Information	Ms. Elke Wisch Representative United Nations Children's Fund Nepal (UNICEF, Nepal) UN House, Pulchowk, Lalitpur, P.O. Box 1187, Zip Code: 44700 Kathmandu, Nepal Tel (office): +977 1 5523200 Ext. 1100 Mobile: +977 9801021469, 9851021469 Facsimile: + 977-1-5527280, 5535395 Email: ewisch@unicef.org Skype: elke.wisch
3	How long (months/year) this organization has been working in Province since ……	1978

<table>
<tr><td>4</td><td>Office Address in the Province (Including Telephone, Website)</td><td colspan="2">United Nations Children's Fund (UNICEF)
Field Office Janakpur, Janakpur-12, Province 2</td></tr>
<tr><td>5</td><td>Contact Person for Province Health Program (Name, Position, Mobile/Phone & Email)</td><td>Health:
Ms. Beki Prasai,
Health Officer, UNICEF
Janakpur field Office
Mobile: 9849256649, 9855011837
Email: bprasai@unicef.org

Ms. Lata Bajracharaya,
Health Officer, UNICEF
Janakpur field Office
Mobile: 9851003905, 9801348419
Email: lbajracharaya@unicef.org</td><td>Nutrition:
Mr. Phulgendra Singh
Nutrition Officer, UNICEF
Janakpur Field Office
Mobile: 9855011832, 9842658861
Email: ppsingh@unicef.org

Mr. Sumi Maskey
Nutrition Officer, UNICEF
Janakpur Field Office
Mobile: 9855011842, 9841494497
Email: smaskey@unicef.org</td></tr>
<tr><td>6</td><td>Organizational Description in brief</td><td colspan="2">UNICEF is dedicated to advancing the rights of all children in Nepal, especially the most marginalized and disadvantaged.

UNICEF began operations in Nepal from its New Delhi office in 1964. The two-person liaison office established in Kathmandu in 1968, finally became a full-fledged office in 1972.

Over five decades of partnership, UNICEF in Nepal has contributed towards many strides the country has taken. The focus of programmes has continuously changed over the years to meet the changing needs of children, adolescents and women in Nepal.

UNICEF continues to advocate for investing in children at the federal, provincial and local levels to maximize the potential of Nepal's young population, and supports Nepal's renewed commitments to achieve the Sustainable Development Goals (SDGs). UNICEF's programmes for 2018-2022 will focus on areas related to health; nutrition; child protection; education; water, sanitation and hygiene; and social protection. Aside from these, early childhood development, adolescents, disability, gender as well as disaster risk reduction and climate change adaptation are issues that will be tackled across sectors.

FACTS: UNICEF Nepal
• is a United Nations agency that signs its five-year country programmes with the Government.
• is not an international non-government organization (INGO).
• works through government and non-government partners and does not implement programmes.
• provides support for strengthening existing government systems mainly through advocacy, policy dialogue and training</td></tr>
</table>

7	Major Health (Thematic Areas) and health sector related programs targeting SDG and UHC	**Nutrition** • Maternal, Infant and Young Child Nutrition (MIYCN): Capacity building of Health Workers, FCHVs, mothers/caretakers • Integrated Management of Acute Malnutrition (IMAM): Capacity building of health workers, FCHVs, district and local level stakeholders; supply support- RUTF, height board, weighing scale-SECA and technical monitoring • Micronutrients (Vitamin A, Iron and Folic Acid for Pregnant, Lactating mothers and Adolescent, Multiple Micronutrient Powder (MNP): Capacity building of health workers, FCHVs, district and local level stakeholders; supply support- MNP, Vitamin A and technical monitoring • Multi-sector Nutrition Plan (MSNP)-Nutrition Sensitive Interventions: capacity building of the local levels, involved sectors, technical backstopping, monitoring and coordination and DRR (Nutrition in Emergency): Technical support to Health and Nutrition Clusters for Preparedness, Response and Recovery **Maternal, Newborn, Child and Adolescent Health** • Maternal and Newborn Health (MNH): Technical Support on MNH related policy guideline development, Evidence based planning & budgeting, capacity building of Health Workers (MNH update training, Skilled Birth Attendance, Clinical Training Skills, EOC monitoring, Infection prevention,) and FCHVs. Special New Born Care Unit (SNCU)/ Kangaroo Mother Care (KMC) service establishment and equipment support. Point of Care at Quality Improvement (POcQI) at Zonal /district hospitals. Advocacy to hard to reach community people/ Quality Improvement support, supportive monitoring visit including HMIS data quality support. • Child Health: Technical support on Child Health guideline & policy development, Capacity building training to health workers on Community Based Integrated Management of Newborn and Childhood Illness (CBIMNCI). EPI related training (EVM, Micro planning, EPI training, DQSA, denominator survey, defaulter tracking, technical support on Social mobilization on EPI & advocacy, Onsite coaching / mentoring. Technical support on Cold Chain Equipment (CCE), District Vaccine Store and Subcenters and vaccines and CCE support. • Adolescent Sexual Reproductive Health (ASRH) and Prevention of Mother to child transmission of HIV (PMTCT): Technical support for strengthening of quality ASRH and PMTCT services: Capacity building of health workers, FCHVs on ASRH and PMTCT. Monitoring / onsite coaching at ASRH & PMTCT service sites. • System Strengthening and Disaster Response & Recovery Health in Emergency activities: Support on provincial and palika level Review/ Planning and HMIS data verification/

		compilation. Disaster response support to health and nutrition cluster meeting, Preparedness Response and Recovery planning , emergency supply support (IEHK medicine, Bed net, blankets and baby incentive kit)
8	Program Components	• **Nutrition** • **Maternal, Newborn, Child and Adolescent Health**
9	Target Group/Beneficiaries by programme	Adolescent girls (10-19 years), Women of reproductive age (15-49 years), children of 0-59 months
10	Implementing Partners (INGOs/NGOs/CSOs)	Government Partnership
11	Program / Projects (With Duration, Total Budget & Donor)	2018-2022 UNICEF and European Union for Nutrition Program
12	Working/Implementation Approach (Redbook, Direct, NGOs)	UNICEF Program and Budget System is - on book, on treasury system (Both the programs and funds reflected in the REDBOOK): NUTRITION and HEALTH Additional for HEALTH: on book, off Treasury system (Programs are reflected in the REDBOOK but fund is provided through Direct Cash Transfer modality)
13	Budget Plan/Expenditure of Health Programs in Province • Expenditure in 2018 • Budget for 2019 • Projected for 2020	**Budget Plan/Expenditure of Nutrition Programs in Province** • Budget in 2017/18: NPR 159,099,000 • Budget in 2018/19: NPR 184,202,000 • Projected for 2020: NPR 184,198,000 Budget Plan/Expenditure of Health Programs in Province • Expenditure in 2018: • Budget for 2019: • Projected for 2020:
14	Upcoming Program/Projects (Name, District, Budget, Donor)	**Nutrition program in 136 Palikas of eight districts of Province # 2** • Maternal, Infant and Young Child Nutrition (MIYCN): Capacity building of Health Workers, FCHVs, mothers/caretakers • Integrated Management of Acute Malnutrition (IMAM): Capacity building of health workers, FCHVs, district and local level stakeholders; supply support- RUTF, height board, weighing scale-SECA and technical monitoring • Micronutrients (Vitamin A, Iron and Folic Acid for Pregnant, Lactating mothers and Adolescent, Multiple Micronutrient Powder (MNP): Capacity building of health workers, FCHVs, district and local level stakeholders; supply support- MNP, Vitamin A and technical monitoring

		• Multi-sector Nutrition Plan (MSNP)-Nutrition Sensitive Interventions: capacity building of the local levels, involved sectors, technical backstopping, monitoring and coordination and DRR (Nutrition in Emergency): Technical support to Health and Nutrition Clusters for Preparedness, Response and Recovery **Health program in 24 convergent palikas of eight districts of Province # 2:** • (Tilathi Koiladi, Kanchanpur, Rajbiraj, Janakpur Dham, Mithila, Jaleshwor, Mahottari, Parsagadi, Birjunj, Kalaiya Bara, Durgabhagwati, Gaur, Chakraghatta, Malangwa Municipalities, Aaurahi, Chhireshwornath, Bardibas, Ekdara, Jaganathpur, Pokhariya, Ishanath NP, Katahariya, Godaita and Narhara). 2. EPI program: All 136 Municipalities and Rural Municipalities • Technical support on planning, review and policy development activities • Technical support on quality maternal newborn child adolescent and Prevention of Mother to Child Transmission of HIV • Capacity building of Health Workers, FCHVs on Maternal newborn updated training, Skilled Birth training, Clinical training skills training, Emergency Obstetric Mentoring, CB-IMNCI, EPI , EVM, microplanning training, Child Adolescent mental health training • System strengthening, data verification review workshop • Disaster response planning and response

3. UNFPA

SN	Particular	Information
1	Name of Organization (With Logo & Main Office Address, Website)	UNFPA Nepal, Sanepa Lalitpur www.nepal.unfpa.org
2	Head of the Organization and Contact Information	Lubna Baqi Email: baqi@unfpa.org Cell No 9801056001
3	How long (months/year) this organization has been working in Province since ……	Since 10 Years
4	Office Address in the Province (Including Telephone, Website)	UNFPA Nepal , Regional Support Office, Janakpurdham-4 www.nepal.unfpa.org,
5	Contact Person for Province Health Program (Name, Position, Mobile/Phone & Email)	Dr. Narendra Mishra , Regional Development Coordinator ,email; nmishra@unfpa.org , Cell No 9801608233

6	Organizational Description in brief	UNFPA, the United Nations Population Fund, is a voluntary-funded international organization with a presence in over 150 countries, including Nepal. UNFPA is guided by the Programme of Action of the 1994 Cairo International Conference on Population and Development (ICPD) and the Sustainable Development Goals. Its mission is to ensure that every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled. **UNFPA in Nepal** UNFPA support to Nepal began in 1971 and has evolved in response to the changing national contexts. The current 8th Country Programme (2018-2022) is in line with Sustainable Development Goals, ICPD Programme of Action, the UN Development Assistance Framework (UNDAF) for Nepal and national priorities set by the Government of Nepal. UNFPA partners with the Government of Nepal, youth and women's organizations and development partners to advance its mission.
7	Major Health (Thematic Areas) and health sector related programs targeting SDG and UHC	**Sexual and reproductive health and rights:** UNFPA is supporting national efforts in Nepal to improve the sexual and reproductive health of the most marginalized adolescent girls and women. The Fund is largely focusing on youth aged 15-24 and the most marginalized women addressing both the demand and supply sides of reproductive health services to improve access to information and services on maternal health, family planning, and sexually transmitted infections, including HIV. **Gender equality:** UNFPA's support to the Government of Nepal under this overarching theme seeks to ensure that vulnerable groups experience greater self-confidence, respect and dignity. We are building national capacity in the health sector to address gender-based violence (GBV), prevent child marriage and other harmful practices, and working to enhance the knowledge and capacity of men, women and communities to GBV. **Adolescents and youth:** Investing in young people, especially the vulnerable and the marginalized, is a priority for UNFPA Nepal. The country has a large adolescent and youth population. Nepal is experiencing a demographic window of opportunity, a 'youth bulge'. Nepali youth face several development challenges, including access to education, employment, gender inequality, child marriage, youth-friendly health services and adolescent pregnancy. Yet, with investments in their participation and leadership, young people can transform the social and economic fortunes of the country. UNFPA Nepal works with the government and partners to advocate for adolescents and youth's rights and investments, including education, livelihood skills and health, including sexual and reproductive health. **Population dynamics:** Population megatrends at the national and sub-national levels in Nepal continued rapid population growth,

		population aging, urbanization and migration — not only frame the entire development debate, they demand a reconsideration and re-conceptualization of what will be the main challenges for a new Nepal. Without an adequate understanding of how Nepal is changing from a demographic perspective, forward-looking planning and agenda setting will be of little value. Keeping this in mind, UNFPA Nepal is working with the government to ensure that national, sectoral and decentralized policies and plans address population dynamics and the interlinkages with gender equality, poverty reduction, the needs of young people, and reproductive health, including family planning.
8	Program Components	• **Sexual and reproductive health and rights** • **Gender equality** • **Adolescents and youth** • **Population dynamics**
9	Target Group/Beneficiaries by programme	Mothers, Childs and adolescents
10	Implementing Partners (INGOs/NGOs/CSOs)	• ADRA Nepal • FPAN • MSI • Red-Cross • WEM
11	Program / Projects (With Duration, Total Budget & Donor)	2018-2022, 30.8 million dollar (DFID,AUS-AID, Swiss Agency etc)
12	Working/Implementation Approach (Redbook, Direct, NGOs)	Redbook and I/NGO
13	Budget Plan/Expenditure of Health Programs in Province • Expenditure in 2018 • Budget for 2019 • Projected for 2020	NA
14	Upcoming Program/Projects (Name, District, Budget, Donor)	• Gender base violence prevention and response • Family Planning and Reproductive Health • Humanitarian Response

4. IPAS

SN	Particular	Information
1	Name of Organization (With Logo & Main Office Address, Website)	Ipas Nepal Baluwatar, Ward No 4, Pabitra Workshop Chowk Tel: 977-1-4420787 Fax: 977-1-425379 Email: ipas@ipas.org Web: www.nepal.ipas.org
2	Head of the Organization and Contact Information	Dr Popular Gentle, CD Baluwatar, Ward No 4, Pabitra Workshop Chowk Tel: 977-1-4420787 Fax: 977-1-425379 Email: gentlep@ipas.org Web: www.ipas.org
3	How long (months/year) this organization has been working in Province since ……	Total years: more than 7 years (Since 2013) but districts are phase wise manner (3 to 5 years in one district and moving another new districts)
4	Office Address in the Province (Including Telephone, Website)	Health office Siraha and Health Office Sarlahi Name: Rajib Kumar Chaudhary Email: chaudharyr@ipas.org Contact no: 9842320442
5	Contact Person for Province Health Program (Name, Position, Mobile/Phone & Email)	Health office siraha and Health Office Sarlahi Name: Rajib Kumar Chaudhary Email: chaudharyr@ipas.org Contact no: 9842320442 Kedar Bhandari (Email Communication) Email : Bhabdarik@ipas.org Contact : 9851241029
6	Organizational Description in brief	**Overview** Ipas Nepal, a non-governmental organization, has been providing technical support to the Ministry of Health and population (MoHP) and different divisions and centers such as Family welfare Division (FWD), National Health Training Center (NHTC), Management Division (MD), Logistics Management Division (LMD), National Health Education, Information and Communication Center (NHEICC) to initiate and expand Safe Abortion Services (SAS) in the country since the legalization of abortion in 2002. Ipas Nepal is currently working with closely coordinating Province and Local government especially with concerning health offices. • **2008:** Registered with the Social Welfare Council (SWC) • **2017:** MOU with MoHP • Supported expansion of SAS in **45 districts** In province 2 Ipas Nepal is working since 2013 and now we are on two districts (Sarlahi and Siraha)

		Mission Women and girls have improved sexual and reproductive health and rights through enhanced access to and use of safe abortion and contraceptive care.
7	Major Health (Thematic Areas) and health sector related programs targeting SDG and UHC	Major Program Focus: Safe abortion and Post abortion contraceptive care, Quality improvement, capacity building, youth friendly services, advocacy and monitoring and evaluation. 1. Center level:- Support in preparation of Protocol, Guideline, conduct MA/2nd trim abortion training, training materials of Safe Abortion and post abortion family planning and other policy guidelines 2. Province Level: Engage and support in program planning, review and implementation of SAS activities, joint program sharing and monitoring and program improvement. 3. District and Palika level: HF preparation/materials support, Orientation to staff and HFOMC, Safe Abortion (Medical Abortion, 2nd Trimester) clinical mentoring support, Monitoring and Evaluation, capacity building of Local body and advocacy. 4. Community: - Community awareness/referrals, advocacy for sustainability and community ownership 5. Quality Improvement:- Orientation on QI process, clinical mentoring/coaching to ensure competent and confident of service provider, quality improvement through COPE (Client Oriented Provider Efficient), community mobilization, SAE reporting and follow up, data review and use 6. Study and evaluation of Safe Abortion Service data monitoring, review and Client Exit Interview in selected HFs.
8	Program Components	Safe abortion services: ○ **Expanding access** to quality safe abortion service (SAS) ○ Support in making process of **policies/guidelines/manuals** ○ **Training to service providers** (ANMs, ob/gyn, MDGP) & developing capacity of **trainers & clinical mentors** ○ Improving and **strengthening health facilities for quality services:** hospitals, PHCCs, HPs ○ Establishing and strengthen **SAS training centers** ○ disseminating **data on SAS/study**
9	Target Group/Beneficiaries by programme	Reproductive age of Women and adolescents
10	Implementing Partners (INGOs/NGOs/CSOs)	N/A
11	Program / Projects (With Duration, Total Budget & Donor)	Duration: July 2019 – June 2020 Budget: NPR 2590000.00 Donor: Ipas
12	Working/Implementation Approach (Redbook, Direct, NGOs)	Logistics support by Partner NGO of center level, TA in training and materials support directly/NGO through but in close coordination with concerning health offices/HFs and HFOMC.

13	Budget Plan/Expenditure of Health Programs in Province • Expenditure in 2018 • Budget for 2019 • Projected for 2020	1. Expenditure in 2018 – NPR 4190000.00 2. Budget for 2019 – NPR 4090000.00 3. Projected for 2020 – NPR 2590000.00
14	Upcoming Program/Projects (Name, District, Budget, Donor)	

5. ADRA

SN	Particular	Information
1	Name of Organization (With Logo & Main Office Address, Website)	ADRA Adventist Development and Relief Agency (ADRA) Nepal, Sanepa, Lalitpur Telephone: +977-1-5555913/14; Fax: +977-1-5554251; P.O. Box no.:4481; Email: info@adranepal.org; Website: www.adranepal.org
2	Head of the Organization and Contact Information	1. Leighton Fletcher, Country Director, leighton.fletcher@adranepal.org 2. Ms. Bidya Mahat, Program Director, bidya.mahat@adranepal.org
3	How long (months/year) this organization has been working in Province since ……	2015
4	Office Address in the Province (Including Telephone, Website)	Janakpur, Sarlahi & Rautahat
5	Contact Person for Province Health Program (Name, Position, Mobile/Phone & Email)	Nirmal Kushwaha, Sarlahi, 046-520216, 9849036736
6	Organizational Description in brief	The Adventist Development and Relief Agency (ADRA) is a global humanitarian organization with a mission to work with people in poverty and distress to create just and positive change. Across its worldwide network of 131 offices, ADRA has developed strong health expertise with a specific focus on community and first-line health facilities. In 2017 ADRA served approximately 2.8 million people in 103 projects through health sector programming. ADRA has been active in Nepal since 1987 with health projects in 29 of the 55 districts. ADRA works with 300 health facilities in 150 municipalities across 20 districts, encompassing all provinces. Additionally, ADRA has a strong community presence in Provinces 2, 5 and 7.

7	Major Health (Thematic Areas) and health sector related programs targeting SDG and UHC Or themes related to SDGs	• Health System Strengthening related to Birthing Center's upgradation • Reproductive Health/Family Planning • Adolescent Sexual and Reproductive Health (ASRH) • Nutrition • Basic Health Logistic supply and Procurement System Strengthening • Non-Communicable Diseases (NCD) • Women Health & System Strengthening (WHSS) related Uterine Prolapse • Maternal, Newborn and Child Health • **Post-Partum Family Planning (PPFP)** **Sustainable Development Goals:** Goal 3. Ensure healthy lives and promote well-being for all at all ages Targets: 3.1, 3.2 and 3.7 Goal 5. Achieve gender equality and empower all women and girls Targets: 5.3 and 5.6 **NHSS specific targets:** Goal Level Indicators G1: Maternal mortality ratio (per 100,000 live births) G2: Under five mortality rate (per 1,000 live births) G4: Total fertility rate (births per 1,000 women aged 15–19 years)
8	Program Components	• Health System Strengthening including Birthing Center's infrastructure upgradation and renovation • Reproductive Health/Family Planning • Adolescent Sexual and Reproductive Health (ASRH) including RUPANTARAN package • Basic Health Logistic supply and Procurement System Strengthening • FP-EPI integration, FP Micro-planning, Nutrition, Emergency Health Response through RH/FP Camps, Community System Strengthening through advocacy and Social and Behaviour Change Communication (SBCC) • Post-Partum Family Planning (PPFP) • Non-Communicable Diseases (NCD) • Women Health & System Strengthening (WHSS) related Uterine Prolapse • Maternal, Newborn and Child Health • Guideline and protocols development • Research & Innovation
9	Target Group/Beneficiaries by programme	20 districts covering 6 provinces of Nepal except province 4 under 4 projects Rural/Urban Municipalities covered-225, Wards-1350 and Health Facilities-392 (Sunsari, Udaypur, Okhaldhunga, Sarlahi, Rautahat, Mohattari, Saptari, Sindhuli, Kavre, Kapilbastu, Pyuthan, Rolpa, Rukum,

		Argakhanchi, Dang, Achham, Baitadi, Bajura, Bhajang and Dadeldhura)
10	Implementing Partners (INGOs/NGOs/CSOs)	Environment and Rural Development Center (ENRUDEC), Banke, Bagmati Welfare Society Nepal, Sarlahi, Rastriya Rojgar Parbardhan Kendra, Sarlahi
11	Program / Projects (With Duration, Total Budget & Donor)	2022
12	Working/Implementation Approach (Redbook, Direct, NGOs)	Direct & NGOs
13	Budget Plan/Expenditure of Health Programs in Province • Expenditure in 2018 • Budget for 2019 • Projected for 2020	Budget for Health sector FY 2017/2018 Total Budget for program's activities: US $ 1527457.44 Total expenses of all program's activities: US $ 1161327.23 Total Budget for 2019 & 2020: US $ 3912996
14	Upcoming Program/Projects (Name, District, Budget, Donor)	Menstrual Health and Hygiene Management (MHM) Project Burn Injuries and its deformity Institutionalization of immediate Post-partum Family Planning (PPFP) initiatives

6. Save The Children

SN	Particular	Information
1	Name of Organization (With Logo & Main Office Address, Website)	Save the Children Save the Children International Sinamangal, Kathamandu Nepal Website; www.savethechildren.org 014464803
2	Head of the Organization and Contact Information	NA
3	How long (months/year) this organization has been working in Province since ……	TB, HIV and Malaria Program in all districts of Prov02: Till March 2021 Sponsorship program: Mahottari & Sarlahi: 2019-2028 Saptari: 2014-2023
4	Office Address in the Province (Including Telephone, Website)	Save the children International Eastern Field Office Bardibas Municipality - 02, Mahottari
5	Contact Person for Province Health Program (Name, Position, Mobile/Phone & Email)	Ajay Kant Associate Director 977-44-550720, 550721 ajay.kant@savethechildren.org

6	Organizational Description in brief	
7	Major Health (Thematic Areas) and health sector related programs targeting SDG and UHC	**1. Active Case finding in TB program through** - sputum transportation system - Contact tracing of bacteriologically confirmed TB cases - Screening SAM/MAM/ARI cases for TB - testing all presumptive Drug Resistance case for GeneXpert - Engaging private health care provider for reporting of TB cases - Finding Actively Separating and treating (FAST) implementation in major hospitals for TB case detection and infection control 2. **HIV Program**: -Care and support services for PLHIVs and CLHIVs - Cash transfer to CLHIVs - BCC service to targeted population (PWID, MSM, MSW, TG) - Providing commodities to the KPs (Needle syringe, condom, lubricants) - Community led testing/index testing at community level - Counselling and linkage to HTC/ART center 3. **Malaria Program** - Case based investigation of malaria cases - LLIN distribution 4. **Sponsorship Program: Maternal and Neonatal Health (MNH**) Capacity Building of Health workers: MNH Update Capacity building of HFOMC Strengthening of Health Mother Group Support to Birthing centers/ Health Facilities My First Baby (MFB) Initiative 5. **Sponsorship Program: Adolescent Sexual and Reproductive Health (ASRH**) SRH/AFS orientation and training to health workers Awareness raising among parents and adolescents Mobilization of child clubs Partner Defined Quality (PDQ) Approach 6. **Sponsorship Program**: Basic and Refresher Training on School Health and Nutrition to focal teachers First Aid training to focal teachers Hygiene Traffic light training to teachers and students SHN related equipment/material support to schools Support to ensure safe drinking water source at schools Awareness raising
8	Program Components	
9	Target Group/Beneficiaries by programme	
10	Implementing Partners (INGOs/NGOs/CSOs)	Bagmati Welfare Society Nepal (BWSN), Harion, Sarlahi National Association of people living with HIV/AIDS (NAP+N) Blue Diamond Society (BDS) Student Awareness Forum (BIJAM)

		Society for Positive Atmosphare and Related Support to HIV and AIDs (SPARSHA) Nepal Community Family Welfare Association (CFWA), Mahottari Ratauli Yuba Club (RYC), Mahottari Rural women Upliftment Association (RWUA), Sarlahi Rastriya Rojgar Prawardhan Kendra (RRPK), Sarlahi Sabal Nepal, Saptari Save the Saptari (StS), Saptari
11	Program / Projects (With Duration, Total Budget & Donor)	TB, HIV and Malaria Program: Till March 2021 Sponsorship program: Mahottari & Sarlahi: 2019-2028 Saptari: 2014-2023
12	Working/Implementation Approach (Redbook, Direct, NGOs)	Under TB, HIV & Malaria program: some activities are implemented through red book and some through partner organization Sponsorship: Working in partnership with local NGOs and local government
13	Budget Plan/Expenditure of Health Programs in Province • Expenditure in 2018 • Budget for 2019 • Projected for 2020	NA
14	Upcoming Program/Projects (Name, District, Budget, Donor)	NA

7. NHSSP

SN	Particular	Information
1	Name of Organization (With Logo & Main Office Address, Website)	Nepal Health Sector support program-NHSSP-DFID Address:-Dhangadhimai municipality, siraha, province-2 Web site:-www.nhssp.org.np
2	Head of the Organization and Contact Information	Nepal Health Sector support program-NHSSP-DFID Patandhoka, Osis complex, Lalitpur **Tel:** +977 1 4264-250 / 4264-301
3	How long (months/year) this organization has been working in Province since ……	31-December-2020

4	Office Address in the Province (Including Telephone, Website)	Nepal Health Sector support program-NHSSP-DFID Address:-Dhangadhimai municipality, siraha Cell no-9851171116 Web site:-www.nhssp.org.np
5	Contact Person for Province Health Program (Name, Position, Mobile/Phone & Email)	Jeetendra nayak Dhangadhimai municipality,siraha Health System Strengthening Officer Cell no:- 9851171116 Email: Jeetendra@nhssp.org.np
6	Organizational Description in brief	The Nepal Health Sector Support Programme 3 (NHSSP 3) is funded by UK Aid from the UK government, and is being implemented from April 2017 to December 2020. It is designed to support the goals of the National Health Sector Strategy (NHSS) and is focused on enhancing the capacity of the Ministry of Health and Population (MoHP) to build a resilient health system to provide quality health services for all. The capacity enhancement of organizations, systems and people will be achieved through nuanced and responsive approaches that build on a deep understanding of the MoHP in Nepal. The programme is managed by four core partners: Options, HERD International, Miyamoto and Oxford Policy Management with an approach that ensures each partner contributes to the planning and delivery of the programme with a shared focus on achieving results for the UK government and Government of Nepal (GoN) over the next four years. The programme has two components. The first component is General Technical Assistance to increase the capacity of the Ministry of Health and Population to improve health policy-making and planning, procurement and financial management, health services, and the use of evidence for planning and management. The second component aims to increase the Ministry of Health and Population's capacity to retrofit health infrastructure to withstand future earthquakes The Programme consists of five work streams: • Health Policy and Planning (HPP) • Procurement and Public Financial Management (PPFM) • Service Delivery (SD) • Evidence and Accountability (E&A) • Health Infrastructure (HI)

7	Major Health (Thematic Areas) and health sector related programs targeting SDG and UHC	Key Areas of Support at Dhangadhimai municipality • RDQA at Facility level • MSS at Facility level • OCAT at municipal level Addressing the capacity gaps • Capacity assessment • Development of action plan • Implementation of the plan • Capacity enhancement for the delivery of quality health services. Other major areas of support • Data analysis • evidence based advocacy • Technical advise • social mapping • coordination and facilitation • supportive supervision, mentoring
8	Program Components	Key Areas of Support at Dhangadhimai municipality • RDQA at Facility level • MSS at Facility level • OCAT at municipal level Addressing the capacity gaps • Capacity assessment • Development of action plan • Implementation of the plan • Capacity enhancement for the delivery of quality health services. Other major areas of support • Data analysis • evidence based advocacy • Technical advise • social mapping • coordination and facilitation • supportive supervision, mentoring
9	Target Group/Beneficiaries by programme	All Health facilities of Dhangadhimai Nagarpalika, siraha-all program service users.
10	Implementing Partners (INGOs/NGOs/CSOs)	Dhangadhimai Nagarpalika, siraha
11	Program / Projects (With Duration, Total Budget & Donor)	31-December-2020
12	Working/Implementation Approach (Redbook, Direct, NGOs)	all Health facilities of Dhangadhimai Nagarpalika, siraha
13	Budget Plan/Expenditure of Health Programs in Province	

	• Expenditure in 2018 • Budget for 2019 • Projected for 2020	
14	Upcoming Program/Projects (Name, District, Budget, Donor)	

8. WHH

SN	Particular	Information
1	Name of Organization (With Logo & Main Office Address, Website)	welt hunger hilfe For a world without hunger Welthungerhilfe Nepal Country Office Bakhundole, Lalitpur P.O. Box 20600, Kathmandu, Nepal. www.welthungerhilfe.de
2	Head of the Organization and Contact Information	Country Director (vacant) Kiran Thapa- Administration and Finance Manager (acting) Telephone: +977 (1) 5552060 | 5520437
3	How long (months/year) this organization has been working in Province since ……	2 years since August 2017
4	Office Address in the Province (Including Telephone, Website)	1. Rajbiraj, Saptari: Phone: 031-521087 2. Mirchaiya, Siraha: Phone: 033-550181 3. Siraha Bazar, Siraha: Phone: 033-520501 4. Gaur, Rautahat: Phone: 055-521625
5	Contact Person for Province Health Program (Name, Position, Mobile/Phone & Email)	Deependra Chaudhari Project Coordinator (Partner Advisor) – Nutrition Governance T: 031-521087 M: +977 9842843775 | 9819959985 S: deependra.chaudhari E: Deependra.Chaudhari@welthungerhilfe.de
6	Organizational Description in brief	WHH Nepal first started to work in 1972. From 2004 onwards, numerous integrated community development projects have been implemented through Nepali NGO partners in several districts. WHH was registered with the Government of Nepal (GoN) through the Social Welfare Council (SWC) on 29 May 2012 and has opened a Country Office in the same year. Welthungerhilfe works hand in hand with civil society in Nepal to

		empower socially marginalized and economically poor citizens to reinforce their resilience and to ensure their right to adequate food and nutrition.
7	Major Health (Thematic Areas) and health sector related programs targeting SDG and UHC	Food Security and Nutrition: targeting to SDG-2 'Zero Hunger by 2030' ; SDG-3 'Good health and Wellbeing' and SDG-6 'Clean water and Sanitation' WASH Governance: Targeting to SDG-6 'Clean water and Sanitation'
8	Program Components	• Food Security and Nutrition • Right to Food and Empowerment • WASH • Disaster Risk Reduction (DRR)
9	Target Group/Beneficiaries by programme	Food Security and Nutrition: Under 5-year children, women of reproductive age (15-45 years), poor, Dalits, disadvantaged and marginalized families. WASH Governance: Entire population
10	Implementing Partners (INGOs/NGOs/CSOs)	Aasaman Nepal-NGO Forward Nepal-NGO Sabal Nepal-NGO Mahuli Community Development Center (MCDC)- NGO
11	Program / Projects (With Duration, Total Budget & Donor)	Regional Programme for Promoting a Multisectoral Approach for Nutrition Smart Village in Bangladesh, India and Nepal • Duration: 2 Years (September 2018-August 2020) • Total Budget: 319,700 euro (Operational Cost) • Donor: Federal Ministry of Economic Cooperation and Development (BMZ), Germany Promoting Citizen Empowerment (Utthan): • Duration: 4 Years (August 2018-October 2021) • Total Budget: 433,936 Euro (Operational Cost) • Donor: Federal Ministry of Economic Cooperation and Development (BMZ), Germany WASH Governance: • Duration: 4 Years (November 2018-December 2021) • Total Budget: 216,402,578 euro (Operational Cost) • Donor: Federal Ministry of Economic Cooperation and Development (BMZ) and Viva con Agua Germany Livelihood: • Duration: 2 Years (September 2018-August 2020) • Total Budget: 92,561,280 euro (Operational Cost) • Donor: Federal Ministry of Economic Cooperation and Development (BMZ), Germany
12	Working/Implementation Approach (Redbook, Direct, NGOs)	NGOs partnership approach

13	Budget Plan/Expenditure of Health Programs in Province • Expenditure in 2018 • Budget for 2019 • Projected for 2020	Nutrition Smart Village Project	Promoting Citizen Empowerment (Utthan)	Livelihood	WASH Governance Promoting
		Euro 219,600	Euro 60,975	Euro 49,981,200	Euro 5,132,040
		Euro 78,600	Euro 179,457	Euro 20,452,320	Euro 15,828,912
		Euro 21,500	Euro 118,930	Euro 22,127,760	Euro 14,144,760
14	Upcoming Program/Projects (Name, District, Budget, Donor)	NA			

9. PSI

Name of Agency/Organization:	Population Services International/Nepal (PSI/Nepal)		
Address:	Krishna Galli, Pulchowk, Lalitpur		
Working District:	Lalitpur Metropolitan City		
Municipality/Rural municipality:			
Duration:	2016-2019		
Major Programs/ Activities	Health with major focus on Family Planning and Safe Abortion		
1	Public Sector Health Facilities strengthening through training and availability of FP and Safe Abortion services		
2	Private clinics/hospitals strengthening through training and availability of FP and Safe Abortion services		
3	Social marketing of OK IUCD and Medabon (MA Drug)		
4	IPC and PBCC		
5	Community Awareness Activities		
Working Modality:	Engaging government and Local NGOs for implementation of the project activities in all the districts		
Contact details: PSI/Nepal, Krishna Galli, Lalitpur, Nepal			
Name of Contact Person	Designation	Contact no	Email
Arjun Subedi	Program Manager	9841418987	arjunsubedi@psi.org.np
Ashok Kumar Yadav	Field Officer	9854036058	ashokyadav@psi.org.np
Name of Partner Organization:	HURENDEC, Udayapur (Triyuga Municipality, Gaighat, Udayapur) for Saptari and Siraha		
	AASMAN Nepal (Janakpur Municipality, Dhanusha) for Dhanusha, Mahottari, Sarlahi, Rautahat, Bara and Parsa		

10. Birat Nepal Medical Trust (BNMT)

SN	Particular	Information
1	Name of Organization (With Logo &Main Office Address, Website)	Birat Nepal Medical Trust (BNMT) Lazimpat, Kathmandu www.bnmt.org.np
2	Head of the Organization and Contact Information	Mr. Suman Chandra Gurung 9840094489 scgurung@bnmt.org.np
3	How long (months/year) this organization has been working in Province since ……	July 2017 to December 2019
4	Office Address in the Province (Including Telephone, Website)	Health Office, Dhanusha
5	Contact Person for Province Health Program (Name, Position, Mobile/Phone & Email)	Mr. Ram Narayan Pandit District Program Coordinator 9844054354 ramnarayan@bnmt.org.np
6	Organizational Description in brief	BNMT Nepal is a Nepalese non-governmental organization dedicated towardsthe improved health and well-being of Nepalese people. It was established 2012. BNMT Nepal envisions a new Nepal where all Nepalese are aware of their basic rights and are able to live healthy and productive lives, in a safe environment without having to worry about food, income or security regardless of their gender, ethnicity, disability or HIV status. BNMT Nepal is built on the foundation of commitment, expertise and experience of the Britain Nepal Medical Trust (BNMT UK), which has been working in Nepal since 1967. **Vision:**To Improve health and wellbeing of Nepalese people. **Mission:** To ensure equitable access to quality health care and enabling environment for socially and economically disadvantaged people. **Current Projects:** IMPACT TB, SRH, TB Reach and DroTS
7	Major Health (Thematic Areas) and health sector related programs targeting SDG and UHC	Tuberculosis Sexual and Reproductive Health
8	Program Components	**Tuberculosis (Province -2 IMPACT TB Project)** Mental Health Research Study of Economic of Tuberculosis Sexual and Reproductive Health Menstrual Health Management DroTS Projects
9	Target Group/Beneficiaries by programme	All people of Dhanusha and Mahottari districts
10	Implementing Partners (INGOs/NGOs/CSOs)	No

11	Program / Projects (With Duration, Total Budget & Donor)	IMPACT TB: Implementing proven community-based active case finding interventions in Nepal" Tuberculosis Duration: 2.5 years EU(European Union)
12	Working/Implementation Approach (Redbook, Direct, NGOs)	Direct Approach
13	Budget Plan/Expenditure of Health Programs in Province • Expenditure in 2018 • Budget for 2019 • Projected for 2020	
14	Upcoming Program/Projects (Name, District, Budget, Donor)	IMPACT TB 2, Mahottari Nick Simonds Foundation (NSF)

11. FPAN

Name of Agency/Organization:	FAMILY PLANNING ASSOCIATION OF NEPAL		
Address:	Janakpur -4 uttimpur		
Working District:	Dhanusha		
Municipality/Rural municipality:	Janakpurdham sub-metropolicity,Mithila Municipality,Janak Nandani Rural Municipality, Aurahi Rural municipality, Ganeshman charnath municipality, Kshireswarnath municipality, Dhanushadham municipality, Nagarain Municipality, Hansapur municipality		
Duration:	Ongoing		
Major Programs/ Activities			
1	All FP Service		
2	Clinical Service		
3	SAS		
4	GBV		
5	YOUTH And SRH		
Contact details:			
Name of Contact Person	Designation	Contact no	Email
Murari Prasad Upadhyay	Branch Manager	9855073913	fpandhanusha@fpan.org.np

ANNEX

Estimated Target Population FY 2075/76 (2018/19)

District/Organization	Total Population	Exp. Live Births	00 - 11 Months	02 - 11 Months	12 - 23 Months	00 - 23 Months	06 - 23 Months	00 - 35 Months	00 - 59 Months	06 - 59 Months	12 - 59 Months	Total: 10-19 Years	Female: 15-44 Yrs	WRA 15-49 Years	MWRA 15-49 Years	Expected Pregnancy	60 & + Years
Province-2	**6113061**	**128439**	**124422**	**120316**	**128814**	**253236**	**191025**	**379293**	**624595**	**562384**	**500173**	**1256876**	**1549188**	**1701214**	**1289520**	**151461**	**524929**
Saptari	**699664**	**15197**	**14722**	**14236**	**14577**	**29299**	**21938**	**43565**	**71328**	**63967**	**56606**	**143618**	**183299**	**201286**	**152575**	**17921**	**60091**
Saptakoshi	23504	511	495	479	491	986	739	1428	2213	1966	1718	5124	6626	7327	5554	603	2107
Kanchanrup	58591	1273	1233	1192	1250	2483	1867	3662	5873	5257	4640	12321	15785	17311	13122	1501	5073
Agnisair Krishnasabaran	29816	648	627	606	579	1206	893	1769	2858	2545	2231	6213	8356	9188	6965	764	2699
Rupani	28807	626	606	586	639	1245	942	1875	3106	2803	2500	5780	7486	8230	6238	738	2414
Sambhunath	38422	835	808	781	740	1548	1144	2274	3698	3294	2890	8107	10494	11515	8728	985	3453
Khadak	49495	1075	1041	1007	1055	2096	1576	3103	5026	4506	3985	10895	13574	15014	11381	1268	4379
Surunga	48463	1053	1020	986	906	1926	1416	2799	4487	3977	3467	10439	13429	14823	11236	1242	4346
Balan-Bihul	23865	518	502	485	528	1030	779	1571	2662	2411	2160	4414	5756	6333	4800	611	2337
Bodebarsain	47072	1022	990	957	1027	2017	1522	3043	5079	4584	4089	9516	11852	12992	9848	1205	4210
Dakneshwori	46445	1009	977	945	990	1967	1479	2968	4981	4493	4004	9186	11739	12931	9802	1190	4211
Rajgadh	32119	698	676	654	661	1337	999	2013	3383	3045	2707	6458	8059	8893	6741	823	2891
Bishnupur	25318	550	533	515	601	1134	868	1713	2819	2553	2286	5057	6481	7087	5372	649	1862
Rajbiraj	76321	1656	1607	1556	1255	2862	2054	4095	6517	5709	4910	16602	20591	22445	17012	1952	5821
Mahadeva	31108	676	655	633	718	1373	1046	2091	3508	3181	2853	6134	7848	8601	6520	797	2421
Tirahut	24260	527	510	493	469	979	724	1444	2359	2104	1849	4625	6366	6927	5251	621	2137
Hanumannagar Kankalini	50003	1086	1052	1017	1231	2283	1757	3475	5752	5226	4700	10053	12595	13793	10455	1281	3952
Tilathi Koiladi	35006	760	737	713	756	1493	1125	2223	3623	3255	2886	6560	8530	9429	7147	896	3012
Chhinnamasta	31049	674	653	631	681	1334	1008	2019	3384	3058	2731	6134	7732	8447	6403	795	2766
Siraha	**693410**	**15372**	**14891**	**14400**	**14343**	**29234**	**21789**	**43271**	**70590**	**63145**	**55699**	**142184**	**185409**	**203604**	**154332**	**18127**	**59565**
Lahan	101009	2239	2169	2098	1748	3917	2830	5660	9136	8049	6967	21679	27552	30064	22788	2640	7659
Dhangadhimai	52121	1155	1119	1082	946	2065	1506	2995	4810	4251	3691	11065	14136	15446	11708	1362	4156
Golbazar	56917	1262	1222	1182	1078	2300	1689	3356	5418	4807	4196	12267	15888	17361	13160	1488	4444
Mirchaiya	53459	1185	1148	1110	1035	2183	1609	3190	5150	4576	4002	10980	14229	15554	11790	1397	4579
Karjanha	34189	758	734	710	736	1470	1103	2172	3503	3136	2769	7108	9312	10226	7751	894	3083
Kalyanpur	53262	1181	1144	1106	1386	2530	1958	3806	6134	5562	4990	10822	14470	16022	12145	1393	5041
Naraha	20981	465	451	436	478	929	704	1393	2284	2059	1833	4364	5599	6135	4650	548	1745
Bishnupur	20104	446	432	418	517	949	733	1438	2349	2133	1917	4000	5316	5902	4474	526	1853
Arnama	24671	547	530	513	609	1139	874	1743	2918	2653	2388	5060	6512	7183	5445	645	2279
Sukhipur	40282	893	865	836	799	1664	1232	2453	4003	3571	3138	8009	10470	11609	8800	1053	3671
Laxmipur Patari	30376	673	652	630	707	1359	1033	2035	3320	2994	2668	6170	7798	8577	6501	794	2770
Sakhuwanankarkat ti	20223	448	434	420	399	833	616	1241	2065	1848	1631	3887	5419	5947	4508	528	1976
Bhagawanpur	22821	506	490	474	438	928	683	1382	2309	2064	1819	4482	5775	6350	4813	597	2219
Nawarajpur	20708	459	445	430	384	829	607	1237	2093	1871	1648	3865	5401	5912	4481	541	1888
Bariyarpatti	27410	608	589	570	581	1170	876	1758	2937	2643	2348	5287	6742	7475	5666	717	2468
Aurahi	24844	551	534	516	508	1042	775	1549	2564	2297	2030	4874	6406	7113	5392	650	2151
Siraha	90033	1996	1933	1869	1994	3927	2961	5863	9597	8631	7664	18265	24384	26728	20260	2354	7583
Dhanusha	**828401**	**17588**	**17038**	**16476**	**17395**	**34433**	**25914**	**51456**	**84582**	**76063**	**67544**	**170234**	**212140**	**232958**	**176582**	**20741**	**71137**
Ganeshman Charnath	39739	844	817	790	910	1727	1319	2584	4187	3779	3370	8562	10667	11649	8830	995	3454
Dhanusadham	49645	1054	1021	987	1096	2117	1607	3193	5296	4786	4275	10359	13051	14321	10855	1243	4429
Mithila	50327	1069	1035	1001	913	1948	1431	2843	4576	4059	3541	10573	13177	14320	10855	1261	4580
Bateshwor	23881	507	491	475	512	1003	758	1489	2402	2157	1911	4822	5792	6377	4834	598	2042
Chhireshwornath	46274	982	952	921	977	1929	1453	2888	4752	4276	3800	9576	11974	13105	9934	1158	3420
Laxminiya	31125	661	640	619	572	1212	892	1797	2984	2664	2344	6300	7943	8766	6645	779	2552
Mithila Bihari	36836	782	758	733	819	1577	1198	2375	3921	3542	3163	7336	9323	10211	7740	922	3297
Hansapur	41548	882	855	827	893	1748	1321	2640	4415	3988	3560	8544	10645	11758	8913	1040	3894
Sabaila	56910	1208	1170	1131	1331	2501	1916	3761	6161	5576	4991	11680	14371	16010	12136	1425	5296
Sahidnagar	51750	1099	1064	1029	1244	2308	1776	3496	5751	5219	4687	10528	13128	14411	10924	1296	5012
Kamala	42073	893	865	836	1040	1905	1473	2908	4833	4401	3968	8384	10522	11647	8828	1053	4057
Janak Nandini	27685	588	569	550	699	1268	984	1945	3241	2957	2672	5622	7104	7784	5900	693	2438
Bideha	35450	753	729	705	792	1521	1157	2296	3793	3429	3064	6946	9040	9937	7532	888	2977
Aurahi	24767	526	509	492	520	1029	775	1545	2564	2310	2055	4881	6151	6727	5099	620	2305
Janakpur	180066	3823	3705	3583	3024	6729	4871	9767	15857	13999	12152	38504	47334	51752	39227	4509	13088
Dhanauji	23431	497	482	466	478	960	719	1430	2351	2110	1869	4681	5806	6401	4852	586	2191
Nagarain	39058	829	803	777	898	1701	1300	2592	4332	3931	3529	7439	9584	10606	8039	978	3772
Mukhiyapatti Musaharmiya	27836	591	573	554	677	1250	964	1907	3166	2880	2593	5497	6528	7176	5439	697	2333
Mahottari	**696650**	**15114**	**14642**	**14159**	**14520**	**29162**	**21841**	**43372**	**71026**	**63705**	**56384**	**143008**	**182305**	**200195**	**151748**	**17823**	**59833**
Bardibas	73569	1596	1546	1495	1160	2706	1933	3825	5983	5210	4437	16278	20875	22761	17253	1882	6529
Gausala	74338	1613	1562	1510	1471	3033	2252	4477	7295	6514	5733	16004	19521	21305	16149	1902	5608
Sonama	42754	928	899	869	1039	1938	1489	2954	4916	4467	4017	8317	10321	11299	8565	1094	3666
Aurahi	34872	757	733	709	782	1515	1149	2291	3824	3458	3091	6921	8925	9716	7365	893	2965
Bhanggaha	51623	1120	1085	1049	1108	2193	1651	3271	5359	4817	4274	10950	14453	15916	12064	1321	4171
Loharpatti	44100	957	927	896	1179	2106	1643	3200	5197	4734	4270	8916	11992	13188	9997	1129	4125
Balawa	46652	1012	981	949	1024	2005	1515	3006	4962	4472	3981	9502	12091	13270	10059	1193	4640
Ram Gopalpur	33129	719	696	673	836	1532	1184	2352	3949	3601	3253	6857	8359	9188	6965	848	3027
Samsi	37078	804	779	753	885	1664	1275	2554	4321	3932	3542	7623	9146	9999	7579	948	3185
Manara Shisawa	55189	1197	1160	1122	1063	2223	1643	3281	5374	4794	4214	11147	14078	15595	11821	1412	4940
Ekdara	32197	699	677	655	647	1324	986	1989	3348	3010	2671	6677	7928	8775	6651	824	2672
Mahottari	30506	662	641	620	531	1172	852	1710	2800	2480	2159	5941	7955	8766	6645	781	2793
Pipara	39864	865	838	810	735	1573	1154	2278	3627	3208	2789	8144	10502	11604	8796	1020	3667
Matihani	34175	741	718	694	780	1498	1139	2277	3817	3458	3099	6819	9010	9885	7493	874	2725
Jaleshwor	66604	1444	1400	1355	1280	2680	1976	3907	6254	5550	4854	12912	17149	18928	14346	1702	5120
Sarlahi	**874663**	**18157**	**17589**	**17008**	**18505**	**36094**	**27298**	**54202**	**89439**	**80643**	**71850**	**179941**	**219000**	**240491**	**182292**	**21412**	**75101**
Lalbandi	68868	1430	1385	1339	1092	2477	1785	3522	5540	4848	4155	15633	19295	21216	16082	1686	6217
Hariwan	50708	1053	1020	986	746	1766	1256	2493	3928	3418	2908	11598	14275	15584	11813	1242	4659
Bagmati	46628	968	938	907	712	1650	1181	2341	3696	3227	2758	10593	13134	14319	10854	1142	4269
Barahathawa	79597	1652	1601	1548	1842	3443	2643	5188	8456	7656	6855	16721	20472	22222	16844	1948	6488
Haripur	42511	882	855	827	937	1792	1365	2700	4442	4015	3587	9197	11164	12291	9317	1040	3129
Ishworpur	68294	1418	1373	1328	1332	2705	2019	4002	6543	5857	5170	14448	17938	19771	14986	1672	5923
Haripurwa	40626	843	817	790	934	1751	1343	2685	4531	4123	3714	7650	9670	10624	8053	994	3368
Parsa	24371	506	490	474	548	1038	793	1592	2708	2463	2218	4609	5519	6167	4675	597	2011
Bramhapuri	33530	696	674	652	805	1479	1142	2265	3790	3453	3116	6680	7983	8849	6708	821	2620

District/Organization	Total Population	Exp. Live Births	00 - 11 Months	02 - 11 Months	12 - 23 Months	00 - 23 Months	06 - 23 Months	00 - 35 Months	00 - 59 Months	06 - 59 Months	12 - 59 Months	Total: 10-19 Years	Female: 15-44 Yrs	WRA 15-49 Years	MWRA 15-49 Years	Expected Pregnancy	60 & + Years
Chandranagar	37678	782	758	733	882	1640	1261	2511	4213	3834	3455	7668	8972	9880	7489	922	3083
Kabilasi	47724	991	960	928	1061	2021	1541	3077	5159	4679	4199	9347	11337	12479	9459	1169	3937
Chakraghatta	31482	654	633	612	731	1364	1048	2088	3511	3195	2878	6078	7291	8060	6109	771	2751
Basbariya	26666	554	536	518	661	1197	929	1840	3071	2803	2535	5143	6393	7070	5359	653	2151
Dhankaul	27927	580	562	543	714	1276	995	1968	3289	3008	2727	5411	6660	7310	5541	684	2273
Ramnagar	32592	677	655	633	761	1416	1089	2167	3628	3301	2973	6223	7670	8327	6312	798	3012
Balara	51571	1071	1037	1003	1121	2158	1640	3250	5358	4840	4321	10071	12146	13251	10044	1263	5003
Godaita	53864	1118	1083	1047	1274	2357	1816	3592	5967	5426	4884	10525	12391	13701	10385	1318	5152
Bishnu	27954	580	562	543	572	1134	853	1717	2897	2616	2335	5396	6425	7093	5376	684	2567
Kaudena	29433	611	592	572	653	1245	949	1901	3208	2912	2616	5656	7057	7736	5864	721	2516
Malangawa	52639	1091	1058	1025	1127	2185	1650	3303	5504	4969	4446	11294	13208	14541	11022	1287	3972
Rautahat	**817585**	**16664**	**16143**	**15610**	**17400**	**33543**	**25472**	**50570**	**83701**	**75630**	**67558**	**168345**	**201001**	**220726**	**167310**	**19651**	**70196**
Chandrapur	88785	1810	1753	1695	1252	3005	2129	4215	6555	5679	4802	19478	25244	27647	20956	2134	7364
Gujara	55886	1139	1103	1067	1041	2144	1593	3176	5215	4664	4112	12335	14653	16074	12184	1343	4281
Fatuwa Bijayapur	43309	883	855	827	862	1717	1290	2560	4205	3778	3350	9163	10791	11819	8959	1041	3482
Katahariya	45394	925	896	866	1023	1919	1471	2932	4924	4476	4028	9214	10729	11748	8905	1091	4071
Brindaban	50769	1035	1002	969	1134	2136	1635	3226	5311	4810	4309	10535	12601	13882	10523	1221	4439
Gadhimai	48157	982	951	920	1094	2045	1570	3107	5146	4671	4195	9718	11642	12815	9714	1158	4071
Madhav Narayan	41674	849	823	796	829	1652	1241	2489	4175	3764	3352	8485	9834	10755	8152	1001	3955
Garuda	59589	1215	1177	1138	1207	2384	1796	3613	6107	5519	4930	12234	14133	15517	11762	1433	5179
Dewahi Gonahi	37898	772	748	723	866	1614	1240	2455	4083	3709	3335	7686	8959	9783	7416	910	3499
Maulapur	31157	635	615	595	759	1374	1067	2129	3612	3305	2997	5905	7341	8018	6078	749	2568
Baudhimai	39276	801	775	749	966	1741	1354	2674	4464	4077	3689	7644	8873	9894	7500	945	3662
Paroha	44269	902	874	845	1153	2027	1590	3129	5208	4771	4334	8823	10449	11491	8710	1064	3727
Rajpur	47825	975	944	913	1329	2273	1801	3566	6052	5580	5108	9822	11544	12649	9588	1150	3971
Yamunamai	28168	574	556	538	651	1207	929	1859	3148	2870	2592	5603	6816	7427	5630	677	2533
Durga Bhagawati	27263	556	538	520	581	1119	850	1676	2734	2465	2196	5521	6470	7158	5426	656	2555
Rajdevi	36537	745	721	697	823	1544	1184	2332	3827	3467	3106	7274	8564	9374	7105	879	3312
Gaur	42523	865	842	814	692	1534	1109	2224	3612	3187	2770	8884	10466	11499	8715	1019	3230
Ishanath	49106	1001	970	938	1138	2108	1623	3208	5323	4838	4353	10021	11892	13176	9987	1180	4297
Bara	**806070**	**16455**	**15940**	**15414**	**17147**	**33087**	**25117**	**49866**	**82514**	**74544**	**66574**	**165962**	**198478**	**217955**	**165210**	**19404**	**69206**
Nijgadh	42694	872	844	816	623	1467	1045	2046	3135	2713	2291	9490	11914	13077	9912	1028	4578
Kolhawi	52530	1072	1039	1005	814	1853	1334	2647	4208	3689	3169	11486	14448	15899	12051	1264	4825
Jitpur Simara	140772	2874	2784	2692	2390	5174	3782	7495	12004	10612	9220	30629	38134	41667	31584	3389	10321
Parwanipur	26534	542	525	508	629	1154	892	1765	2939	2677	2414	5582	6430	7050	5344	639	1806
Prasauni	29127	595	576	557	620	1196	908	1815	3040	2752	2464	6157	7079	7761	5883	702	2170
Bishrampur	27614	564	546	528	720	1266	993	1977	3358	3085	2812	5335	6312	6864	5203	665	2295
Pheta	29659	605	587	568	789	1376	1083	2126	3538	3245	2951	6159	6948	7562	5732	713	2370
Kalaiya	143898	2934	2843	2749	3169	6012	4588	9117	15169	13745	12326	30008	34765	38168	28931	3460	11231
Karaiyamai	31189	637	617	597	630	1247	939	1856	3033	2725	2416	6474	7656	8541	6474	751	2644
Baragadhi	31965	653	632	611	651	1283	967	1914	3133	2817	2501	6694	7772	8558	6487	770	3083
Adarsha Kotwal	31873	651	630	609	844	1474	1159	2298	3889	3574	3259	6031	7160	7904	5991	768	3054
Simroungadh	56366	1151	1115	1078	1287	2402	1845	3696	6277	5720	5162	10705	12713	14138	10717	1357	5252
Pacharauta	39526	807	782	756	950	1732	1341	2698	4641	4250	3859	7562	9006	9855	7470	952	3839
Mahagadhimai	61075	1247	1208	1168	1511	2719	2115	4183	6983	6379	5775	11904	14286	15644	11858	1471	5780
Devtal	27080	553	536	518	650	1186	918	1821	3053	2785	2517	5272	6055	6699	5078	652	2929
Subarna	34168	698	676	654	870	1546	1208	2412	4114	3776	3438	6474	7800	8568	6495	823	3029
Parsa	**696618**	**13892**	**13457**	**13013**	**14927**	**28384**	**21656**	**42991**	**71415**	**64687**	**57958**	**143584**	**167556**	**183999**	**139471**	**16382**	**59800**
Thori	24637	491	476	460	348	824	586	1147	1752	1514	1276	5415	6699	7397	5607	579	3201
Jirabhawani	26500	528	512	495	604	1116	860	1684	2743	2487	2231	5158	6692	7402	5611	623	2472
Jagarnathpur	37542	749	725	701	973	1698	1336	2634	4420	4058	3695	7134	8485	9385	7114	883	3467
Paterwa Sugauli	27717	553	535	517	581	1116	849	1696	2844	2577	2309	5431	6714	7463	5657	652	2508
Sakhuwa Prasauni	38087	760	736	712	882	1618	1250	2479	4147	3779	3411	7939	9283	10227	7752	896	3124
Parsagadhi	44912	896	868	839	1045	1913	1479	2924	4853	4419	3985	9315	11221	12280	9308	1057	3927
Birgunj	280685	5598	5422	5245	5143	10565	7852	15660	25759	23046	20337	61672	69959	76382	57898	6600	19374
Bahudarmai	45548	908	880	851	1152	2032	1592	3157	5330	4890	4450	8897	10278	11279	8549	1071	4097
Pokhariya	40740	812	787	761	1024	1811	1418	2807	4726	4333	3939	7758	9232	10172	7710	958	3894
Kalikamai	24391	486	471	455	569	1040	805	1609	2734	2499	2263	4643	5464	5951	4511	573	2635
Dhobini	22984	458	444	429	615	1059	837	1638	2715	2493	2271	4308	5079	5665	4294	540	2411
Chhipaharmai	30725	613	594	574	763	1357	1060	2103	3547	3250	2953	5894	7027	7709	5843	723	3301
Pakaha Mainapur	23966	478	463	448	527	990	759	1523	2591	2360	2128	4534	5177	5729	4343	564	2717
Bindabasini	28184	562	544	526	701	1245	973	1930	3254	2982	2710	5486	6246	6958	5274	663	2672

Estimated Target Population FY 2076/77 (2019/20)

District/Organization	Total Population	Exp. Live Births	00 - 11 Months	02 - 11 Months	12 - 23 Months	00 - 23 Months	06 - 23 Months	00 - 35 Months	00 - 59 Months	06 - 59 Months	12 - 59 Months	Total: 10-19 Years	Female: 15-44 Yrs	WRA 15-49 Years	MWRA 15-49 Years	Expected Pregnancy	60 & + Years
Province-2	6209507	128428	124540	120430	127491	252031	189761	378967	629490	567220	504950	1231920	1576813	1733744	1314178	151448	536815
Saptari	707568	15149	14691	14206	14358	29049	21704	43345	71561	64216	56870	140132	185992	204502	155013	17864	61189
Saptakoshi	23765	509	493	477	484	977	731	1420	2220	1974	1727	5002	6715	7436	5636	600	2152
Kanchanrup	59246	1268	1230	1189	1232	2462	1847	3644	5893	5278	4663	12023	16013	17583	13328	1495	5173
Agnisair Krishnasabaran	30146	645	626	605	570	1196	883	1760	2867	2554	2241	6064	8473	9330	7072	761	2747
Rupani	29134	624	605	585	630	1235	933	1866	3116	2814	2511	5639	7600	8366	6341	736	2458
Sambhunath	38845	832	807	780	728	1535	1132	2262	3710	3307	2903	7911	10644	11695	8865	981	3514
Khadak	50012	1071	1038	1004	1038	2076	1557	3085	5042	4523	4004	10630	13769	15251	11560	1263	4458
Surunga	48981	1049	1017	983	891	1908	1400	2783	4501	3993	3484	10186	13612	15047	11406	1237	4423
Balan-Bihul	24148	517	501	484	520	1021	771	1563	2670	2420	2169	4307	5848	6442	4883	610	2375
Bodebarsain	47600	1019	988	955	1012	2000	1506	3028	5096	4602	4108	9283	12030	13204	10009	1202	4283
Dakneshwori	46982	1006	975	943	974	1949	1462	2952	4997	4510	4022	8960	11921	13148	9966	1186	4286
Rajgadh	32476	695	674	652	650	1324	987	2001	3393	3056	2719	6300	8180	9038	6851	820	2939
Bishnupur	25609	548	532	514	592	1124	858	1704	2828	2562	2296	4932	6579	7203	5460	646	1897
Rajbiraj	77173	1652	1604	1554	1237	2841	2036	4077	6542	5737	4938	16203	20880	22785	17272	1948	5927
Mahadeva	31468	674	653	631	708	1361	1035	2080	3519	3193	2866	5986	7969	8744	6628	795	2467
Tirahut	24558	526	510	493	461	971	716	1437	2366	2111	1856	4512	6462	7039	5336	620	2176
Hanumannagar Kankalini	50573	1083	1050	1015	1215	2265	1740	3460	5771	5246	4721	9810	12783	14016	10624	1277	4028
Tilathi Koiladi	35442	759	736	712	745	1481	1113	2213	3635	3267	2899	6400	8664	9589	7268	895	3069
Chhinnamasta	31410	672	652	630	671	1323	997	2010	3395	3069	2743	5984	7850	8586	6508	792	2817
Siraha	700665	15336	14871	14380	14109	28980	21545	43028	70754	63319	55883	138606	188291	207030	156929	18085	60604
Lahan	102073	2234	2166	2094	1719	3885	2799	5630	9159	8073	6993	21140	27957	30542	23151	2633	7807
Dhangadhimai	52673	1153	1118	1081	930	2048	1489	2978	4821	4262	3703	10792	14346	15695	11897	1360	4234
Golbazar	57499	1259	1220	1180	1059	2279	1669	3336	5430	4820	4210	11961	16124	17641	13372	1485	4524
Mirchaiya	54020	1182	1147	1109	1016	2163	1590	3170	5161	4588	4014	10702	14459	15824	11995	1394	4657
Karjanha	34540	756	733	709	724	1457	1091	2160	3512	3146	2779	6929	9451	10392	7877	892	3136
Kalyanpur	53799	1178	1142	1104	1365	2507	1936	3784	6148	5577	5006	10546	14709	16308	12361	1389	5122
Naraha	21193	464	450	435	470	920	695	1384	2288	2063	1838	4254	5684	6236	4727	547	1777
Bishnupur	20317	445	431	417	510	941	726	1431	2354	2139	1923	3898	5403	6007	4553	525	1886
Arnama	24914	545	529	512	600	1129	865	1733	2924	2660	2395	4932	6611	7302	5535	643	2319
Sukhipur	40718	891	864	835	786	1650	1218	2439	4013	3581	3149	7807	10635	11809	8951	1051	3732
Laxmipur Patari	30693	672	651	630	696	1347	1022	2024	3329	3004	2678	6014	7921	8724	6613	792	2821
Sakhuwanankarkatti	20440	447	434	420	393	827	610	1235	2070	1853	1636	3789	5503	6047	4584	527	2007
Bhagawanpur	23064	505	490	474	431	921	676	1375	2314	2069	1824	4369	5863	6455	4893	596	2256
Nawarajpur	20939	458	444	429	378	822	600	1231	2098	1876	1654	3767	5487	6013	4558	540	1917
Bariyarpatti	27712	607	588	569	572	1160	866	1749	2945	2651	2357	5153	6851	7606	5765	716	2509
Aurahi	25103	549	533	515	498	1031	765	1538	2569	2303	2036	4750	6510	7238	5486	647	2187
Siraha	90968	1991	1931	1867	1962	3893	2928	5831	9619	8654	7688	17803	24777	27191	20611	2348	7713
Dhanusha	838084	17535	17004	16443	17141	34145	25643	51212	84896	76394	67892	166174	215287	236713	179428	20678	72458
Ganeshman Charnath	40175	841	815	788	897	1712	1305	2571	4203	3796	3388	8358	10822	11832	8969	992	3516
Dhanusadham	50203	1050	1019	985	1080	2099	1590	3178	5317	4808	4298	10111	13252	14559	11036	1238	4511
Mithila	50936	1066	1033	999	900	1933	1417	2830	4594	4078	3561	10326	13351	14527	11011	1257	4672
Bateshwor	24175	506	490	474	506	996	751	1484	2412	2167	1922	4709	5877	6479	4911	597	2082
Chhireshwornath	46825	980	950	919	963	1913	1438	2874	4769	4294	3819	9348	12147	13311	10090	1156	3488
Laxminiya	31499	659	639	618	563	1202	883	1789	2994	2675	2355	6151	8058	8905	6750	777	2598
Mithila Bihari	37276	780	756	731	808	1564	1186	2365	3938	3560	3182	7159	9466	10380	7868	920	3360
Hansapur	42015	879	852	824	879	1731	1305	2626	4432	4006	3580	8338	10809	11954	9061	1037	3961
Sabaila	57537	1204	1167	1128	1310	2477	1894	3740	6183	5600	5016	11393	14597	16283	12343	1420	5387
Sahidnagar	52332	1095	1062	1027	1226	2288	1757	3479	5772	5241	4710	10274	13325	14646	11102	1291	5102
Kamala	42548	890	863	835	1026	1889	1458	2895	4851	4420	3988	8180	10690	11848	8981	1050	4129
Janak Nandini	28004	586	568	549	689	1257	973	1936	3252	2968	2684	5488	7213	7913	5998	691	2484
Bideha	35868	750	728	704	781	1509	1145	2285	3808	3444	3080	6781	9176	10099	7655	884	3030
Aurahi	25068	524	509	492	512	1021	767	1539	2574	2320	2065	4766	6245	6837	5182	618	2346
Janakpur	182201	3813	3698	3576	2977	6675	4822	9720	15911	14058	12213	37598	48000	52550	39831	4495	13342
Dhanauji	23714	496	481	465	471	952	712	1423	2360	2120	1879	4568	5897	6509	4934	585	2234
Nagarain	39538	827	802	776	886	1688	1287	2581	4349	3948	3547	7262	9735	10787	8177	975	3840
Mukhiyapatti Musaharmiya	28170	589	572	553	667	1239	953	1897	3177	2891	2605	5364	6627	7294	5529	695	2376
Mahottari	705838	15111	14654	14170	14323	28977	21650	43238	71387	64060	56733	139790	185534	203999	154631	17820	61040
Bardibas	74528	1596	1547	1496	1144	2691	1918	3815	6014	5241	4467	15922	21204	23150	17548	1882	6674
Gausala	75303	1612	1563	1511	1450	3013	2232	4462	7332	6551	5769	15647	19849	21690	16441	1901	5729
Sonama	43327	928	900	870	1027	1927	1477	2946	4942	4492	4042	8128	10510	11519	8731	1094	3738
Aurahi	35334	756	734	710	771	1505	1138	2284	3844	3477	3110	6764	9093	9909	7511	892	3021
Bhanggaha	52282	1119	1085	1049	1094	2179	1637	3261	5388	4846	4303	10704	14706	16216	12292	1320	4256
Loharpatti	44657	956	927	896	1167	2094	1631	3192	5224	4761	4297	8715	12209	13443	10190	1127	4207
Balawa	47254	1012	981	949	1009	1990	1500	2995	4987	4497	4006	9285	12309	13526	10253	1193	4731
Ram Gopalpur	33543	718	696	673	825	1521	1173	2344	3969	3621	3273	6701	8508	9364	7098	847	3086
Samsi	37556	804	780	754	874	1654	1264	2547	4343	3953	3563	7452	9304	10184	7719	948	3249
Manara Shisawa	55929	1197	1161	1123	1048	2209	1629	3270	5402	4822	4241	10896	14333	15899	12051	1412	5037
Ekdara	32606	698	677	655	638	1315	977	1983	3365	3027	2688	6524	8071	8946	6781	823	2720
Mahottari	30923	662	642	621	522	1164	843	1704	2814	2493	2172	5806	8108	8945	6780	781	2846
Pipara	40404	865	839	811	725	1564	1145	2271	3645	3226	2806	7961	10691	11828	8966	1020	3743
Matihani	34625	741	719	695	770	1489	1130	2271	3837	3478	3118	6666	9177	10080	7641	874	2781
Jaleshwor	67567	1447	1403	1357	1259	2662	1956	3893	6281	5575	4878	12619	17462	19300	14629	1706	5222
Sarlahi	888986	18153	17604	17024	18328	35932	27128	54181	90197	81393	72593	176478	222885	245068	185761	21406	76844
Lalbandi	69962	1429	1385	1339	1079	2464	1772	3518	5587	4895	4202	15336	19607	21590	16365	1685	6378
Hariwan	51511	1052	1020	986	737	1757	1247	2490	3961	3451	2941	11380	14508	15859	12021	1241	4775
Bagmati	47364	967	938	907	703	1641	1172	2338	3726	3257	2788	10392	13344	14567	11042	1140	4375
Barahathawa	80894	1652	1602	1549	1827	3429	2628	5188	8527	7726	6925	16401	20821	22628	17152	1948	6643
Haripur	43179	882	855	827	929	1784	1357	2699	4480	4053	3625	9022	11350	12513	9485	1040	3200
Ishworpur	69397	1417	1374	1329	1317	2691	2004	4002	6601	5914	5227	14170	18249	20141	15267	1671	6065
Haripurwa	41317	844	818	791	926	1744	1335	2685	4570	4161	3752	7501	9856	10840	8217	995	3444
Parsa	24780	506	491	475	542	1033	788	1591	2731	2486	2240	4519	5625	6293	4770	597	2052
Bramhapuri	34073	696	675	653	798	1473	1136	2265	3823	3486	3148	6550	8131	9024	6840	821	2677
Chandranagar	38291	782	758	733	875	1633	1254	2511	4248	3869	3490	7520	9133	10070	7633	922	3153
Kabilasi	48517	991	961	929	1051	2012	1532	3075	5202	4722	4241	9166	11554	12733	9652	1169	4020

District/Organization	Total Population	Exp. Live Births	00 - 11 Months	02 - 11 Months	12 - 23 Months	00 - 23 Months	06 - 23 Months	00 - 35 Months	00 - 59 Months	06 - 59 Months	12 - 59 Months	Total: 10-19 Years	Female: 15-44 Yrs	WRA 15-49 Years	MWRA 15-49 Years	Expected Pregnancy	60 & + Years
Chakraghatta	32010	654	634	613	724	1358	1041	2087	3541	3224	2907	5959	7429	8223	6233	771	2811
Basbariya	27118	554	537	519	655	1192	924	1839	3097	2829	2560	5044	6515	7214	5468	653	2198
Dhankaul	28392	580	562	543	709	1271	990	1968	3318	3037	2756	5305	6784	7455	5651	684	2325
Ramnagar	33143	677	656	634	754	1410	1082	2166	3658	3330	3002	6103	7814	8492	6437	798	3080
Balara	52452	1071	1039	1005	1111	2150	1631	3250	5403	4884	4364	9876	12371	13512	10242	1263	5118
Godaita	54757	1118	1084	1048	1263	2347	1805	3592	6018	5476	4934	10320	12621	13973	10592	1318	5264
Bishnu	28425	580	563	544	566	1129	848	1716	2922	2641	2359	5291	6546	7235	5484	684	2623
Kaudena	29931	611	593	573	646	1239	943	1900	3235	2939	2642	5546	7191	7892	5982	721	2571
Malangawa	53473	1090	1059	1027	1116	2175	1639	3301	5549	5013	4490	11077	13436	14814	11228	1285	4072
Rautahat	835944	16742	16235	15699	17343	33578	25461	50845	84922	76805	68687	166105	205555	226013	171318	19743	72249
Chandrapur	90789	1818	1763	1705	1246	3009	2128	4235	6649	5768	4886	19229	25778	28270	21429	2144	7595
Gujara	57111	1144	1109	1072	1037	2146	1592	3193	5292	4738	4183	12174	14966	16440	12462	1349	4402
Fatuwa Bijayapur	44283	887	860	832	858	1718	1288	2573	4265	3835	3405	9042	11033	12099	9171	1046	3584
Katahariya	46413	930	901	871	1020	1921	1471	2949	4997	4547	4096	9090	10976	12033	9121	1097	4190
Brindaban	51892	1039	1008	975	1131	2139	1635	3244	5389	4885	4381	10394	12886	14214	10774	1225	4567
Gadhimai	49246	986	956	924	1092	2048	1570	3125	5221	4743	4265	9590	11903	13120	9945	1163	4189
Madhav Narayan	42615	853	828	801	825	1653	1239	2502	4236	3822	3408	8371	10064	11019	8352	1006	4067
Garuda	60930	1220	1183	1144	1201	2384	1793	3630	6197	5606	5014	12069	14461	15896	12049	1439	5334
Dewahi Gonahi	38748	776	753	728	863	1616	1240	2469	4142	3766	3389	7582	9167	10021	7596	915	3603
Maulapur	31869	638	619	599	757	1376	1067	2141	3664	3355	3045	5824	7514	8216	6228	752	2640
Baudhimai	40165	804	780	754	963	1743	1353	2689	4530	4140	3750	7540	9087	10146	7691	948	3764
Paroha	45259	906	879	850	1151	2030	1591	3147	5284	4845	4405	8704	10688	11769	8921	1068	3836
Rajpur	48863	979	949	918	1325	2274	1800	3585	6139	5665	5190	9687	11804	12950	9816	1154	4089
Yamunamai	28798	577	559	541	649	1208	929	1869	3193	2914	2634	5527	6971	7605	5765	680	2604
Durga Bhagawati	27883	558	542	524	580	1122	851	1687	2774	2503	2232	5449	6620	7334	5559	658	2628
Rajdevi	37375	749	726	702	821	1547	1184	2346	3883	3520	3157	7178	8766	9606	7281	883	3404
Gaur	43498	872	845	816	689	1534	1107	2235	3666	3239	2821	8769	10709	11781	8930	1030	3327
Ishanath	50207	1006	975	943	1135	2110	1623	3226	5401	4914	4426	9886	12162	13494	10228	1186	4426
Bara	822555	16501	16001	15473	17057	33058	25058	50040	83554	75554	67553	163434	202593	222756	168849	19459	71090
Nijgadh	43560	874	847	819	618	1465	1042	2051	3174	2751	2327	9348	12141	13345	10116	1031	4720
Kolhawi	53588	1075	1042	1008	808	1850	1329	2655	4262	3741	3220	11312	14727	16230	12302	1268	4957
Jitpur Simara	143679	2882	2795	2703	2374	5169	3772	7518	12154	10757	9359	30169	38883	42540	32245	3399	10620
Parwanipur	27078	543	527	510	627	1154	891	1773	2976	2713	2449	5499	6565	7206	5462	640	1856
Prasauni	29715	596	578	559	616	1194	905	1820	3077	2788	2499	6063	7225	7931	6012	703	2233
Bishrampur	28190	566	548	530	718	1266	992	1986	3400	3126	2852	5253	6452	7023	5323	667	2357
Pheta	30254	607	589	570	786	1375	1081	2134	3582	3288	2993	6065	7094	7729	5859	716	2433
Kalaiya	146821	2946	2857	2761	3150	6007	4575	9148	15362	13930	12505	29552	35495	39019	29576	3475	11526
Karaiyamai	31825	638	619	599	627	1246	937	1863	3072	2763	2453	6376	7812	8729	6617	752	2712
Baragadhi	32612	654	634	613	648	1282	965	1921	3173	2856	2539	6594	7931	8744	6628	771	3161
Adarsha Kotwal	32528	653	633	612	841	1474	1158	2308	3938	3622	3305	5936	7315	8085	6128	770	3138
Simroungadh	57538	1154	1119	1082	1280	2399	1840	3708	6356	5797	5237	10538	12996	14472	10970	1361	5387
Pacharauta	40335	809	785	759	945	1730	1338	2707	4699	4307	3914	7444	9200	10079	7640	954	3942
Mahagadhimai	62324	1250	1212	1172	1506	2718	2112	4200	7072	6466	5860	11721	14598	16003	12130	1474	5932
Devtal	27633	554	538	520	647	1185	916	1828	3091	2822	2553	5191	6186	6853	5195	653	3006
Subarna	34875	700	678	656	866	1544	1205	2420	4166	3827	3488	6373	7973	8768	6646	825	3110
Parsa	709867	13901	13480	13035	14832	28312	21572	43078	72219	65479	58739	141201	170676	187663	142249	16393	61341
Thori	25102	492	477	461	345	822	584	1149	1772	1534	1295	5327	6810	7531	5708	580	3295
Jirabhawani	27012	529	513	496	601	1114	858	1688	2774	2518	2261	5071	6816	7550	5723	624	2530
Jagarnathpur	38263	749	727	703	967	1694	1331	2640	4468	4105	3741	7012	8653	9583	7264	883	3553
Paterwa Sugauli	28251	553	536	518	578	1114	846	1700	2877	2609	2341	5339	6841	7615	5772	652	2571
Sakhuwa Prasauni	38793	760	737	713	876	1613	1245	2483	4193	3825	3456	7806	9453	10428	7904	896	3204
Parsagadhi	45757	896	869	840	1040	1909	1475	2931	4906	4472	4037	9160	11422	12516	9487	1057	4032
Birgunj	286004	5601	5430	5252	5102	10532	7812	15684	26052	23332	20622	60667	71221	77856	59015	6605	19897
Bahudarmai	46414	909	881	852	1147	2028	1588	3166	5390	4950	4509	8748	10479	11513	8727	1072	4200
Pokhariya	41526	813	789	763	1019	1808	1414	2815	4779	4385	3990	7628	9418	10389	7875	959	3988
Kalikamai	24855	487	472	456	565	1037	801	1612	2765	2529	2293	4565	5573	6076	4606	574	2696
Dhobini	23428	459	445	430	613	1058	836	1643	2746	2524	2301	4234	5181	5786	4386	541	2469
Chhipaharmai	31312	613	595	575	759	1354	1057	2108	3587	3290	2992	5794	7165	7870	5965	723	3383
Pakaha Mainapur	24431	478	464	449	523	987	755	1525	2619	2387	2155	4457	5278	5849	4434	564	2787
Bindabasini	28719	562	545	527	697	1242	970	1934	3291	3019	2746	5393	6366	7101	5383	663	2736

Analysed Data: Reporting Status (%)

District/Organization	Average no. of People Served FCHV (reporting Period)	Average no. of People Served ORC (Per Clinic)	Average no. of People Served from Immunization Clinic (Per Clinic)	Percentage of Reporting Status (EPIC)	Percentage of Reporting Status (FCHV)	Percentage of Reporting Status (PHCORC)	Total Emergency Services
Province-2	25.1	19.3	25.8	97.4	93.8	86.9	195096
Saptari	38.4	16.7	24.6	99.5	97.7	95.9	12677
Saptakoshi	100.2	17.2	28	100	100	99	0
Kanchanrup	62.6	20.1	24.6	100	99.3	100	35
Agnisair Krishnasabaran	42.8	9.1	22.5	100	100	96.5	0
Rupani	49.9	22.9	23.8	100	98.5	96.5	732
Sambhunath	40	15.6	20.9	100	100	93.4	0
Khadak	38.3	21.5	25.8	100	95.2	91.5	0
Surunga	46.6	11.7	20.6	100	99.5	94.7	0
Balan-Bihul	18.5	19.4	16.8	100	94.1	86	0
Bodebarsain	31.9	18.5	24.6	99.8	96.8	98.9	0
Dakneshwori	32.4	15.1	25.9	99.1	96.7	96.5	0
Rajgadh	37.5	16.2	21.7	100	114	98.6	0
Bishnupur	32.3	20.4	19.6	100	97.3	100	0
Rajbiraj	38.5	15.9	51.2	93.9	79.7	85.5	10581
Mahadeva	37.8	20.5	29.1	100	99.6	100	0
Tirahut	34.9	11.8	18.4	100.4	97.3	99.6	0
Hanumannagar Kankalini	18.7	17.1	19.8	100	99.9	100	1329
Tilathi Koiladi	22.4	15.7	19.9	99.4	97.5	94.4	0
Chhinnamasta	19.3	12.3	25.6	100	98.4	100	0
Siraha	19.7	16.2	23.3	98.2	93.9	95.1	25578
Lahan	18.7	17.6	25.7	100	98.7	97.2	11940
Dhangadhimai	15.3	19.2	24.7	97.4	100	100	0
Golbazar	27.2	19.5	25.9	94.6	95.4	97.9	3644
Mirchaiya	14.7	12.3	24.4	98.7	93.7	83.2	1538
Karjanha	37.7	25.9	43.4	100	97.9	95.8	2753
Kalyanpur	13.3	15	25.6	96.5	93.8	93	0
Naraha	27.5	18.4	18.4	100	95.3	100	0
Bishnupur	17.3	17.6	22.9	100	96.5	100	0
Arnama	30.2	16.2	30.7	100	97.9	100	0
Sukhipur	19.1	16.4	23	97.8	66.8	98.4	0
Laxmipur Patari	12.5	11	20.4	96	93.3	90.4	0
Sakhuwanankarkatti	14.3	14.6	15.8	101.6	99.2	96.5	0
Bhagawanpur	18.5	9.7	19.9	100	95.4	93.5	0
Nawarajpur	42.6	12.1	23	91.5	96.9	72	0
Bariyarpatti	25.8	19.6	18.9	98.2	100	100	0
Aurahi	15.4	13.3	17.9	97.7	99.4	100	0
Siraha	15.1	14.2	18.9	99.5	94.6	96	5703
Dhanusha	22.5	20.3	27.1	95.9	92.9	83.3	30124
Ganeshman Charnath	26.1	39.4	36.6	95.4	97.7	92.2	0
Dhanusadham	34.5	22.4	59.2	99.6	78.7	63.9	0
Mithila	19.7	19.6	28.9	94.5	97.7	88.8	340
Bateshwor	15.3	20.9	18.4	93.6	99.8	86.1	0
Chhireshwornath	21.3	14.4	40.3	92.2	96.8	95.1	0
Laxminiya	22	21.9	31.5	93.5	99.5	97.2	0
Mithila Bihari	13.4	13.1	25	100	99.6	99.6	0
Hansapur	18.9	23.1	22.7	89.6	98.5	77.3	0
Sabaila	35.3	23.3	33.8	99.8	95.4	82	0
Sahidnagar	23.6	14	18.6	97.5	89.8	77.6	0
Kamala	11.6	21.8	26.7	97.2	96.7	78.2	0
Janak Nandini	23.9	13.2	17.4	99.4	85.5	73.9	0
Bideha	21.4	15	22.3	94.9	95.5	94.9	0
Aurahi	41.9	7.2	27.1	99	70.9	75.2	0
Janakpur	11.1	28.2	22.5	92.9	89.8	68.6	29784
Dhanauji	24.2	23.7	22.4	97.9	99.5	93.2	0
Nagarain	25.6	20.1	25.6	93.5	83.9	82.1	0
Mukhiyapatti Musaharmiya	36.3	27.3	27.2	100	99.1	95.4	0
Mahottari	41.8	29.4	33.3	96.6	95	87.5	14628
Bardibas	30.8	21	21.1	96.6	100	91.3	5874
Gausala	79.8	24.9	44.5	100	99.9	89.3	0
Sonama	39.8	45.4	38.4	95.2	100.7	73.8	0
Aurahi	49.8	15	37.5	100	74.6	91.7	0
Bhanggaha	30.3	34.9	31.1	95.4	94.8	68.4	0
Loharpatti	35.1	24.2	40.4	92.9	97.6	89.1	0
Balawa	28.5	35.8	32.6	96	96.4	97.2	0
Ram Gopalpur	109	26.6	33.5	100	91	74.4	0
Samsi	25.3	30.6	26.2	97.6	99.6	85.4	0
Manara Shisawa	22.8	28.2	27.3	94.6	95	82.9	0
Ekdara	64.4	27.2	28.3	98.3	99.3	99.4	0
Mahottari	42.1	29	35	100	100	92.8	0
Pipara	23.2	36.9	27.6	96.6	94.4	98.4	0
Matihani	59	31.3	39.2	95.7	96.3	96.1	0
Jaleshwor	13.3	31.3	42.2	94.1	83.6	86.4	8754
Sarlahi	20.7	17.7	26.8	97.2	91	80.6	22183
Lalbandi	26.1	24.5	31.4	95.6	97.2	97.1	0
Hariwan	46.7	27.7	31.2	99.6	95.2	98.9	2646
Bagmati	24.4	18.6	31.8	100	91.7	98.5	0
Barahathawa	19	23	41.7	97.8	95.6	79	0
Haripur	19	12.2	42.9	99.6	92.3	97	0
Ishworpur	12.1	15.1	47.3	90.8	83.8	49.3	0
Haripurwa	8.9	16.5	33.8	90.6	78.9	87.1	0
Parsa	2.5	10.2	20.8	95.5	54.8	84.1	0
Bramhapuri	23.3	19.4	24.9	95.8	87.8	85.9	0
Chandranagar	10.4	15.8	25.2	100	96.5	88.4	0

District/Organization	Average no. of People Served FCHV (reporting Period)	Average no. of People Served ORC (Per Clinic)	Average no. of People Served from Immunization Clinic (Per Clinic)	Percentage of Reporting Status (EPIC)	Percentage of Reporting Status (FCHV)	Percentage of Reporting Status (PHCORC)	Total Emergency Services
Kabilasi	42.8	17.8	22.7	94.3	72.8	51.4	0
Chakraghatta	24.8	15.9	28	95.9	98.6	55.3	0
Basbariya	21	9	25.6	98.9	96.7	70.1	0
Dhankaul	16.7	4.6	17.9	96.4	95.5	68.2	0
Ramnagar	12.2	19.7	33.5	100	98.7	82.9	0
Balara	28.9	14.9	17.2	94.8	95.8	77.2	0
Godaita	18.9	22.1	14.8	100	95	76.8	0
Bishnu	6.2	14.2	20.2	100	96.2	100	0
Kaudena	6.8	17.7	21.2	100	99	95	0
Malangawa	10.8	18.2	22	98.6	94.4	95	19537
Rautahat	20.9	18.2	29.4	97.6	94.5	87.8	4649
Chandrapur	25.9	19.6	33.5	93.4	93.6	71.4	25
Gujara	23.2	36.5	42.1	100	99.1	86.9	0
Fatuwa Bijayapur	9.5	16	29	99	99.6	89.9	0
Katahariya	9.9	12.3	29.4	99.7	95.6	99.7	0
Brindaban	23.5	17.6	37.4	97.7	93.1	92.8	0
Gadhimai	8.1	14.1	36.3	92.5	94.7	73.8	0
Madhav Narayan	7.1	10.9	20.8	97.1	94.1	97.3	0
Garuda	13.9	30.4	25	98.7	89.5	73.6	0
Dewahi Gonahi	20.6	18.1	31.9	99.7	97.4	82.4	0
Maulapur	28.8	17.2	27.5	100	95	100	0
Baudhimai	11.7	18.6	21.8	100	97	68.9	0
Paroha	28.4	29.5	29.1	98.9	97.5	97.5	0
Rajpur	30	10.1	31.9	98.9	101.7	87.5	0
Yamunamai	22.7	15.1	31.9	98.5	100	99	0
Durga Bhagawati	18.4	10.9	21.2	89.9	95.9	75.9	0
Rajdevi	53.9	17.8	21.4	97.7	100.3	92.6	0
Gaur	7.2	8.8	74.4	69.7	21	58.8	4624
Ishanath	24.4	19.6	32.6	99.1	91.5	97.6	0
Bara	21.1	19.8	22.6	97.1	93.8	80.2	5157
Nijgadh	16.3	11	31.4	94.2	97	62.6	0
Kolhawi	23.3	24.7	16.2	100	98.6	96	203
Jitpur Simara	38.5	18.8	46.9	92.9	91.6	60.7	0
Parwanipur	22.9	18.4	17.5	95.7	97.9	91.3	0
Prasauni	46.6	11.1	23.8	97.1	91	67	0
Bishrampur	28.9	43.7	20.9	100	101.3	91.4	0
Pheta	11.4	23.7	18.4	100	95.8	100	0
Kalaiya	13.2	14.4	22.4	98.3	85.3	91	4954
Karaiyamai	19.1	23.8	18.8	100	96.2	87.9	0
Baragadhi	26.5	19.5	17.2	100	99.2	93.5	0
Adarsha Kotwal	14.7	11.9	22	100	94.9	100	0
Simroungadh	16.2	21.4	24.5	98.9	97.1	54.3	0
Pacharauta	17	19.9	20.7	97.6	97.2	97.2	0
Mahagadhimai	14.3	14	20	96	92.2	80.6	0
Devtal	16.8	18.1	16.7	100	94.7	97	0
Subarna	32.7	24.5	18.8	84.6	93.9	52.3	0
Parsa	17.8	17.8	20.8	97.4	92.5	83.3	80100
Thori	13.7	13.1	17.3	100	97	97.7	0
Jirabhawani	19.7	28.3	17.2	101.5	100	87.8	0
Jagarnathpur	19	17.7	15.1	100	98.6	100	0
Paterwa Sugauli	17.5	15.3	21.4	95.8	95.1	70.8	0
Sakhuwa Prasauni	31.8	19	26.1	99.3	98.7	99.2	0
Parsagadhi	10.1	23.6	25.1	98.5	94	80.6	0
Birgunj	15.3	15.7	22.7	96.5	75.6	75.2	76488
Bahudarmai	9.6	13.3	16.5	100	98.5	88.6	0
Pokhariya	13.1	12.5	22.6	100	97.1	72.2	3612
Kalikamai	31	18.7	23.4	94.6	99.6	87.2	0
Dhobini	7.8	10.4	13.7	84.6	96	98.1	0
Chhipaharmai	17.9	24.1	21.9	98.7	93.8	56	0
Pakaha Mainapur	10.2	9.7	12.7	98	100	79.3	0
Bindabasini	40.7	34	31.3	100	100	97.1	0

Analysed Data: Immunization

District/Organization	Coverage (% of children under one year immunized)												% of children 12-23 months immunized		% of children <1 yr immunized as per NIP schedule
	BCG	DPT-Hep B-Hib			OPV			PCV			fIPV 2nd dose	MR	MR	JE	
		1st dose	2nd dose	3rd dose	1st dose	2nd dose	3rd dose	1st dose	2nd dose	3rd dose		1st dose	2nd dose		
Province-2	107	114	111	105	106	101	97	108	104	89	42	95	71	82	71
Saptari	102	101	100	97	94	91	88	100	98	90	48	91	77	85	78
Saptakoshi	93	91	90	90	77	76	71	80	79	88	52	88	77	77	97
Kanchanrup	107	107	104	103	93	88	85	107	105	99	52	101	97	92	98
Agnisair Krishnasabaran	102	104	102	98	99	95	92	101	98	94	55	96	105	101	108
Rupani	113	114	107	104	107	103	99	113	106	98	52	98	65	85	64
Sambhunath	108	111	108	107	105	100	99	109	105	93	54	93	87	100	82
Khadak	113	113	115	118	107	107	110	112	113	108	38	107	89	103	107
Surunga	102	101	102	98	95	96	90	98	100	86	42	89	83	92	86
Balan-Bihul	95	98	97	92	95	92	86	96	90	93	25	97	71	84	70
Bodebarsain	96	96	99	98	91	94	91	95	97	81	54	89	75	83	80
Dakneshwori	103	106	102	104	104	90	91	105	97	91	40	96	80	89	91
Rajgadh	98	97	93	93	90	85	86	92	84	82	38	85	64	80	71
Bishnupur	97	92	84	84	88	81	79	88	85	66	48	70	41	56	67
Rajbiraj	97	97	97	84	88	88	74	97	95	79	38	77	82	89	31
Mahadeva	104	100	103	94	91	90	82	97	100	90	60	92	54	67	76
Tirahut	100	97	97	98	84	81	85	96	97	83	67	88	81	82	53
Hanumannagar Kankalini	105	103	103	102	95	96	92	103	104	104	66	104	90	89	101
Tilathi Koiladi	89	88	92	84	82	83	77	88	91	82	45	83	59	66	68
Chhinnamasta	104	97	86	82	97	86	82	97	86	83	53	83	55	59	48
Siraha	116	115	111	112	106	101	101	113	108	96	42	97	82	87	86
Lahan	104	102	96	96	95	90	90	99	93	83	66	86	95	105	69
Dhangadhimai	112	114	109	112	103	97	100	111	109	95	32	96	102	105	81
Golbazar	127	129	123	124	116	107	106	128	122	111	35	113	117	112	108
Mirchaiya	129	126	129	128	116	119	117	124	126	106	54	108	94	98	97
Karjanha	140	136	127	132	124	119	120	129	122	118	53	110	89	90	128
Kalyanpur	148	146	144	148	140	139	140	143	142	126	43	124	87	87	114
Naraha	107	109	111	98	101	100	88	112	112	96	47	96	50	61	87
Bishnupur	123	121	116	115	114	110	108	121	114	115	81	111	72	84	110
Arnama	133	127	127	124	111	103	108	129	128	110	47	110	83	78	87
Sukhipur	111	117	110	110	107	97	96	115	104	87	30	89	77	94	82
Laxmipur Patari	107	106	111	116	96	95	96	105	101	87	29	93	67	74	77
Sakhuwanankarkatti	112	113	113	109	106	105	97	107	102	96	51	104	109	95	110
Bhagawanpur	92	91	83	80	82	77	73	92	82	72	18	73	47	65	49
Nawarajpur	96	98	99	93	84	83	80	95	93	74	9	76	59	60	64
Bariyarpatti	110	111	104	113	102	95	105	110	102	89	24	95	69	84	81
Aurahi	130	126	117	122	121	109	109	121	110	104	17	107	69	86	90
Siraha	97	95	90	91	92	86	88	93	87	78	36	80	57	64	60
Dhanusha	113	141	149	136	125	128	116	133	139	104	38	113	77	101	69
Ganeshman Charnath	114	128	132	128	116	115	109	108	129	94	28	113	98	92	124
Dhanusadham	113	140	147	148	133	129	127	137	139	112	13	116	47	87	76
Mithila	104	113	111	110	101	97	97	111	110	100	34	95	89	102	145
Bateshwor	99	105	108	103	90	90	86	97	95	73	44	83	61	72	53
Chhireshwornath	112	140	130	127	120	111	106	131	118	79	28	103	49	91	75
Laxminiya	111	135	135	128	122	119	109	133	130	97	41	101	74	100	79
Mithila Bihari	101	141	123	114	133	113	109	133	116	101	22	104	45	64	21
Hansapur	134	151	152	146	128	134	121	125	128	96	40	119	78	91	84
Sabaila	155	163	181	175	146	149	151	158	169	126	39	130	80	96	57
Sahidnagar	145	140	149	151	121	123	120	137	134	106	28	115	70	86	62
Kamala	110	144	145	150	123	126	125	133	129	116	39	118	78	96	90
Janak Nandini	95	122	126	124	108	105	104	119	118	98	27	103	57	73	60
Bideha	123	128	137	137	117	122	118	121	125	101	22	104	64	84	82
Aurahi	117	119	132	135	107	111	111	115	120	108	29	138	86	103	87
Janakpur	97	171	196	149	147	169	129	163	191	127	66	130	115	172	31
Dhanauji	116	123	133	130	115	115	106	116	118	100	37	104	96	103	68
Nagarain	94	111	109	98	96	95	79	102	101	70	39	83	49	62	69
Mukhiyapatti Musaharmiya	103	116	108	101	104	98	89	96	89	49	12	91	50	59	93
Mahottari	100	113	107	105	106	99	97	103	98	87	45	98	81	91	80
Bardibas	91	92	87	90	87	82	85	87	86	84	49	87	97	112	58
Gausala	99	115	110	106	106	101	97	110	104	97	43	98	102	104	128
Sonama	100	111	105	105	105	98	98	101	93	83	34	92	61	73	63
Aurahi	82	117	103	104	114	99	97	100	88	80	23	89	58	68	56
Bhanggaha	107	132	128	121	121	115	109	122	120	94	51	112	101	105	96
Loharpatti	128	149	133	132	133	118	114	139	122	104	37	117	75	88	107
Balawa	78	110	97	101	106	96	99	93	80	73	31	97	62	77	53
Ram Gopalpur	133	147	143	143	137	132	129	136	127	100	64	119	62	91	84
Samsi	103	113	109	98	102	99	86	102	104	93	30	99	62	67	61
Manara Shisawa	97	107	106	96	97	94	84	90	92	75	37	90	73	85	111
Ekdara	112	127	111	107	115	101	98	110	97	83	55	106	90	94	78
Mahottari	97	103	105	105	98	96	96	91	96	91	67	99	106	112	90
Pipara	106	104	100	100	99	93	92	92	92	96	62	104	115	115	61
Matihani	112	120	124	125	113	117	120	111	115	108	63	116	112	113	105
Jaleshwor	80	84	82	80	83	79	78	79	78	64	47	71	58	69	47
Sarlahi	101	108	98	90	97	86	78	100	89	74	30	83	57	68	69
Lalbandi	90	99	95	91	93	88	84	94	91	84	38	83	96	115	93
Hariwan	109	108	102	98	98	91	82	104	98	88	49	97	111	125	86
Bagmati	107	103	95	91	93	87	83	95	87	77	28	87	88	116	95
Barahathawa	97	116	105	99	107	96	91	113	99	83	49	85	50	66	66
Haripur	126	121	100	91	98	80	73	110	84	80	33	93	53	73	82
Ishworpur	103	115	103	94	111	99	90	115	102	84	29	85	73	68	72
Haripurwa	77	107	94	80	97	84	71	82	73	53	18	74	38	58	30

District/Organization	Coverage (% of children under one year immunized)												% of children 12-23 months immunized		% of children <1 yr immunized as per NIP schedule
	BCG	DPT-Hep B-Hib			OPV			PCV			fIPV 2nd dose	MR	MR	JE	
		1st dose	2nd dose	3rd dose	1st dose	2nd dose	3rd dose	1st dose	2nd dose	3rd dose		1st dose	2nd dose		
Parsa	136	103	101	89	86	86	76	84	75	59	18	76	40	62	29
Bramhapuri	115	118	105	99	100	86	80	106	90	73	30	83	53	62	111
Chandranagar	105	105	89	83	85	77	71	92	78	64	31	78	63	66	65
Kabilasi	108	94	88	81	90	81	77	89	79	41	19	69	33	44	40
Chakraghatta	130	129	122	112	111	99	87	113	107	84	43	111	70	74	90
Basbariya	85	100	96	91	96	92	87	97	92	78	18	85	52	62	126
Dhankaul	111	115	107	91	98	84	67	113	97	77	8	86	38	51	64
Ramnagar	126	149	125	110	140	105	100	134	104	97	30	104	65	66	42
Balara	81	86	80	76	72	63	59	78	71	58	22	66	30	48	37
Godaita	103	117	104	92	105	89	81	102	94	78	37	90	58	65	86
Bishnu	76	121	106	88	102	85	70	106	93	64	21	77	60	63	96
Kaudena	136	136	124	105	110	98	77	133	120	88	22	93	43	52	80
Malangawa	60	61	53	57	55	48	51	58	51	53	20	52	30	39	10
Rautahat	121	121	114	106	116	109	110	114	107	87	47	94	60	71	54
Chandrapur	81	81	79	77	82	75	75	80	79	74	24	74	93	99	27
Gujara	109	111	103	108	107	101	259	100	95	89	28	105	102	89	79
Fatuwa Bijayapur	126	127	126	117	128	124	117	117	119	96	63	90	76	69	57
Katahariya	143	135	134	110	133	129	106	112	109	85	25	103	46	80	39
Brindaban	120	124	112	104	119	108	97	121	124	77	136	85	42	57	67
Gadhimai	139	127	122	107	113	106	93	120	112	86	71	92	45	61	38
Madhav Narayan	120	121	120	115	119	118	107	117	114	104	56	106	91	94	58
Garuda	116	122	119	113	108	99	92	114	107	88	40	105	64	88	38
Dewahi Gonahi	149	149	142	142	138	124	125	142	138	115	46	116	65	82	106
Maulapur	128	120	117	113	107	99	97	117	115	96	65	100	51	62	89
Baudhimai	119	123	117	102	112	160	88	119	113	81	38	84	27	45	29
Paroha	134	130	121	120	127	118	115	122	105	99	34	115	62	69	100
Rajpur	139	144	134	121	143	132	119	137	123	93	24	97	41	54	38
Yamunamai	103	114	112	102	105	106	97	106	104	72	20	79	36	49	44
Durga Bhagawati	124	122	106	101	114	95	87	120	102	91	51	95	67	86	60
Rajdevi	113	115	113	111	113	109	118	110	112	81	57	88	55	72	42
Gaur	127	122	96	86	109	89	75	111	91	68	64	69	79	59	30
Ishanath	133	134	113	96	132	110	95	120	104	91	31	97	46	60	58
Bara	98	109	105	100	104	100	97	105	101	89	37	93	71	82	79
Nijgadh	82	93	91	83	94	91	84	95	91	82	32	86	99	104	60
Kolhawi	69	73	69	67	71	65	79	71	68	72	24	65	69	73	42
Jitpur Simara	74	95	88	82	92	86	80	93	85	75	19	79	78	89	63
Parwanipur	84	95	89	81	95	87	93	97	88	84	31	87	59	75	69
Prasauni	74	81	77	75	76	71	69	81	76	64	51	67	47	66	72
Bishrampur	108	108	110	105	108	111	105	104	106	95	45	101	61	75	92
Pheta	103	111	109	99	110	108	97	109	102	80	25	80	42	54	45
Kalaiya	121	119	118	113	116	115	110	117	117	101	53	103	79	89	114
Karaiyamai	113	117	113	117	115	108	107	118	110	106	31	108	92	103	88
Baragadhi	103	106	99	102	105	93	100	107	97	91	29	93	77	89	82
Adarsha Kotwal	112	126	121	125	119	114	123	117	112	110	43	110	65	81	94
Simroungadh	115	152	127	125	120	122	117	109	109	95	30	116	68	86	80
Pacharauta	108	120	128	116	114	119	101	121	121	97	64	106	83	91	67
Mahagadhimai	103	117	106	102	112	98	95	113	104	93	50	93	61	73	92
Devtal	95	104	110	105	98	101	94	102	109	85	40	87	59	66	55
Subarna	117	130	126	127	125	120	118	126	123	102	32	110	61	73	91
Parsa	106	102	99	93	98	94	88	95	92	82	49	89	66	73	59
Thori	51	61	60	58	61	60	58	55	55	57	37	62	67	74	44
Jirabhawani	79	86	79	76	84	79	75	78	75	63	53	74	54	58	71
Jagarnathpur	90	94	93	84	93	91	82	79	76	64	37	84	45	53	93
Paterwa Sugauli	102	101	97	93	92	87	81	93	81	68	40	83	58	71	65
Sakhuwa Prasauni	108	113	112	112	107	104	105	108	106	92	54	104	84	95	102
Parsagadhi	101	97	97	95	93	92	90	84	86	76	35	92	65	68	69
Birgunj	118	102	98	92	99	94	88	99	95	85	51	88	79	82	46
Bahudarmai	122	115	106	101	109	101	93	101	96	94	53	99	57	68	55
Pokhariya	94	104	99	100	98	96	94	98	93	86	41	91	64	67	68
Kalikamai	107	102	106	96	97	91	88	95	103	93	57	96	71	77	101
Dhobini	103	116	109	104	116	107	103	104	101	83	59	89	41	57	42
Chhipaharmai	85	101	93	83	92	86	72	95	84	62	43	75	39	51	47
Pakaha Mainapur	94	103	105	99	99	95	89	99	101	88	61	94	61	69	32
Bindabasini	115	118	118	111	112	111	105	109	107	96	59	100	66	71	77

Analysed Data : Immunization

District/Organization	Dropout rate (%)				Wastage rate (%)							
	BCG vs MR1	DPT-HepB-Hib 1 vs 3	DPT-HepB-Hib1 vs MR1	MR1 vs 2	BCG	DPT-HepB-Hib	OPV	PCV	fIPV	MR	JE	TD
Province-2	11.6	7.9	17.2	22.9	75	19	18	12	23	45	45	33
Saptari	10.4	4.4	9.9	16	83	26	27	17	25	52	48	45
Saptakoshi	4.6	1.3	3.3	13.3	68	12	15	18	15	29	30	28
Kanchanrup	5.3	3.7	5.5	2.4	81	21	23	12	21	48	40	30
Agnisair Krishnasabaran	5.5	5.5	6.9	-0.33	84	23	23	10	28	45	49	38
Rupani	13.4	8.7	13.8	30.4	82	23	23	18	30	52	46	39
Sambhunath	13.7	3.5	15.6	14.3	81	21	21	12	17	47	42	40
Khadak	5.7	-4.6	5.6	15	82	21	23	14	23	46	41	33
Surunga	12.5	2.8	11.3	17.5	84	24	24	18	21	55	47	37
Balan-Bihul	-1.9	6.3	1.6	23.1	88	38	40	25	47	60	53	58
Bodebarsain	7	-1.9	7.8	13	86	31	35	28	22	60	54	60
Dakneshwori	7.2	1.9	9.6	15.7	85	30	27	14	35	58	59	47
Rajgadh	12.7	3.8	11.9	27	86	30	30	27	2	61	56	60
Bishnupur	28.1	8.2	24.1	32.9	83	29	27	15	24	64	61	49
Rajbiraj	20.8	14.1	21.1	16.8	73	25	30	15	31	44	42	36
Mahadeva	12.3	6.4	8.5	35.2	80	19	20	16	19	53	51	48
Tirahut	12	-0.81	9.3	15.8	83	26	27	13	21	57	49	61
Hanumannagar Kankalini	0.99	1.4	-0.92	-1.2	84	30	30	24	27	46	41	43
Tilathi Koiladi	6.7	4.3	6.3	26.4	85	35	36	22	36	61	57	60
Chhinnamasta	19.8	15.1	13.9	30.8	78	19	21	12	13	49	46	38
Siraha	15.9	2.7	15.2	19.3	79	19	17	12	24	47	42	32
Lahan	16.9	5.5	15.3	11.5	80	18	18	10	20	47	41	26
Dhangadhimai	14.1	1.7	15.1	10.3	77	34	13	10	17	39	35	26
Golbazar	11.5	4.4	12.9	8.4	80	13	13	8	15	44	39	29
Mirchaiya	16.1	-1	14.3	21.6	77	15	17	12	16	41	42	28
Karjanha	21.2	2.9	19	18.7	70	6	10	3	32	24	34	11
Kalyanpur	16.3	-1.4	15.1	14.5	65	9	9	3	8	22	31	15
Naraha	10.3	10	11.4	44.5	75	21	21	10	4	45	31	36
Bishnupur	9.2	4.6	7.7	22.2	80	17	18	10	19	49	40	35
Arnama	17.2	2.2	13.4	13.5	77	23	21	21	33	51	45	35
Sukhipur	19.7	5.6	23.5	20.4	83	23	22	25	40	57	51	41
Laxmipur Patari	13.6	-9.9	12.3	21.4	82	23	20	20	42	55	46	42
Sakhuwanankarkatti	7.4	3.9	8.4	2.9	85	27	25	16	35	58	54	47
Bhagawanpur	21.2	12.4	20	41.9	77	15	15	7	25	49	46	25
Nawarajpur	20.7	4.6	22.5	32.6	82	29	29	23	46	58	53	40
Bariyarpatti	14	-1.5	14.4	28.8	82	16	17	13	45	63	43	30
Aurahi	17.7	3.6	15.1	38.5	82	27	28	24	34	58	50	48
Siraha	17.7	4	15.8	26.4	81	19	20	13	20	51	45	35
Dhanusha	-0.31	3.7	20.1	30.8	68	16	16	11	19	43	38	29
Ganeshman Charnath	1.1	0	11.8	3.5	58	16	11	12	19	33	22	28
Dhanusadham	-2.6	-5.8	16.9	56.2	53	7	7	4	15	30	28	16
Mithila	9.1	3.1	16.2	17.6	79	30	29	25	38	52	54	48
Bateshwor	16.4	2.1	21.1	23.3	83	26	25	19	34	63	55	55
Chhireshwornath	8.3	9.4	26.7	51	50	10	10	9	12	36	24	18
Laxminiya	9.1	5.7	25.1	34.9	70	15	14	14	24	46	41	29
Mithila Bihari	-3.1	19.1	26.5	53.3	59	16	12	11	32	45	54	23
Hansapur	11.7	3.1	21.4	31.3	62	17	18	17	18	46	40	4
Sabaila	15.9	-7.4	20	30	58	15	14	9	18	40	35	25
Sahidnagar	20.7	-8	18.1	28.3	66	20	20	18	31	50	48	41
Kamala	-7.1	-4.8	17.6	21	73	19	17	15	19	47	36	32
Janak Nandini	-7.7	-1.9	15.6	32.5	80	32	34	23	33	63	63	53
Bideha	15.4	-6.9	18.7	33.8	69	18	18	16	30	52	42	41
Aurahi	-18.7	-13.2	-16.2	36.6	76	19	17	18	31	44	46	38
Janakpur	-34.1	13.2	24.1	27.6	64	10	11	1	2	25	25	16
Dhanauji	10.5	-5.6	15.5	8.8	72	22	21	18	22	57	42	28
Nagarain	12	11.4	25.1	33.7	70	21	21	8	20	48	46	31
Mukhiyapatti Musaharmiya	12.2	12.7	21.6	35.1	74	21	19	22	32	59	48	40
Mahottari	2.2	6.8	13.4	17.6	72	15	15	11	16	38	37	29
Bardibas	4.5	1.9	4.6	16.6	80	23	23	16	21	44	43	31
Gausala	1.1	7.5	15	1.5	65	9	9	4	9	29	18	15
Sonama	8	4.8	16.3	23.6	63	9	6	6	13	34	33	15
Aurahi	-8.1	11.6	24.2	30.6	74	14	14	15	25	30	33	21
Bhanggaha	-5.2	8.6	15.1	8.1	67	14	13	13	12	36	35	35
Loharpatti	8.9	11.5	21.7	18.7	63	11	10	9	9	28	27	21
Balawa	-23.7	7.6	11.8	33.5	75	22	21	12	16	43	44	38
Ram Gopalpur	10.6	2.7	18.6	37.3	70	16	16	11	15	45	40	35
Samsi	4	12.8	12.3	28.7	74	14	14	11	15	44	46	34
Manara Shisawa	7.8	10.4	16.3	25.9	73	13	12	11	21	49	46	28
Ekdara	4.8	15.7	16.4	19.2	74	19	18	18	24	45	47	38
Mahottari	-2.4	-1.8	4.1	11.6	76	15	15	11	20	31	35	30
Pipara	2.2	3.1	-0.23	2.6	75	19	19	13	22	40	46	31
Matihani	-3.7	-4.4	2.6	-4.1	70	14	14	12	12	29	20	24
Jaleshwor	11.1	5.3	15.4	26.2	73	16	17	7	10	44	43	33
Sarlahi	18.3	16.7	23.5	28.3	70	21	20	16	25	45	47	35
Lalbandi	7.2	8	16.1	8.8	75	25	25	17	27	41	42	45
Hariwan	11.5	9.2	10.2	16	78	17	18	15	20	38	38	31
Bagmati	18	11	15	23.4	70	19	17	15	23	37	38	26
Barahathawa	12.3	14.2	26.7	32.4	64	12	11	10	20	39	48	19
Haripur	26.4	24.7	23.3	37.5	65	19	18	13	23	43	39	36
Ishworpur	17.8	18.4	26	16.7	63	15	13	6	18	22	32	25
Haripurwa	3.4	24.8	30.7	41.6	52	19	17	10	23	35	42	23
Parsa	44.4	13.7	26.7	41.1	62	26	22	22	35	48	35	30
Bramhapuri	27.7	16.4	29.4	24.4	65	10	12	8	24	38	30	31
Chandranagar	25.8	20.2	25.1	6.9	74	20	23	20	25	45	46	37

District/Organization	Dropout rate (%)				Wastage rate (%)							
	BCG vs MR1	DPT-HepB-Hib 1 vs 3	DPT-HepB-Hib1 vs MR1	MR1 vs 2	BCG	DPT-HepB-Hib	OPV	PCV	fIPV	MR	JE	TD
Kabilasi	36.6	14.1	27.4	47.4	56	21	19	17	16	44	48	31
Chakraghatta	14.1	13.6	13.7	27.4	68	16	13	12	18	32	42	-5
Basbariya	0.22	9.1	15.3	24.2	76	33	33	22	32	51	42	44
Dhankaul	22.7	21.5	25.5	44.1	66	24	23	21	41	56	59	39
Ramnagar	17.3	26.4	30.3	27	71	17	15	14	22	52	46	39
Balara	18.5	12	23.6	50.8	78	33	33	26	40	59	59	45
Godaita	13.1	21.5	23.6	24.5	81	26	23	22	38	58	62	55
Bishnu	-1.4	27.4	36.4	20.1	74	35	34	33	38	63	70	50
Kaudena	31.8	22.6	32	48.4	72	22	19	18	28	57	61	46
Malangawa	12.4	6	14.6	37.9	52	13	13	6	2	29	27	31
Rautahat	22.6	12.3	22.6	31	72	21	18	15	20	44	57	35
Chandrapur	8.4	5.4	8.4	10.9	65	14	14	15	18	31	37	26
Gujara	3.6	2.3	4.6	8.9	74	16	-21	12	20	29	34	33
Fatuwa Bijayapur	28.7	8.5	29.6	14.6	74	21	22	22	29	42	50	39
Katahariya	27.9	18.4	23.9	49	69	19	19	13	16	40	28	34
Brindaban	28.9	16.5	31.5	44.2	67	20	16	10	-38	47	90	36
Gadhimai	33.9	15.8	27.3	43.5	70	25	25	18	19	47	44	35
Madhav Narayan	11.6	4.8	12.6	13.7	74	8	8	-6	12	35	43	26
Garuda	9.9	7.1	13.6	38	75	26	26	16	26	40	39	39
Dewahi Gonahi	22	4.7	22.3	34.9	70	19	19	13	19	46	40	31
Maulapur	21.8	5.6	16.3	37	75	24	25	21	23	48	55	34
Baudhimai	28.8	16.9	31.1	60.7	78	26	24	24	36	60	62	44
Paroha	14.5	8.2	11.9	29.3	75	24	25	19	35	48	57	41
Rajpur	30.1	16.5	32.8	40	74	21	21	17	17	48	44	39
Yamunamai	22.8	10.1	30.2	46.9	72	35	35	24	55	52	62	53
Durga Bhagawati	23.8	17.6	22.5	23.3	76	20	21	10	22	50	48	26
Rajdevi	21.9	3.3	23.3	28.3	83	22	15	10	21	62	56	32
Gaur	45.7	29.6	43.4	6.2	0	0	0	0	5	0	0	0
Ishanath	27.2	28	27.7	44.2	76	33	33	25	36	55	59	46
Bara	5.7	8.1	15.1	18.1	76	12	12	6	33	46	42	23
Nijgadh	-4.2	10.7	8.4	14.4	65	15	16	5	12	22	27	17
Kolhawi	6.5	8.7	11.4	16	82	25	20	5	20	59	62	36
Jitpur Simara	-7.2	13.5	16.2	15.6	61	9	10	2	75	32	25	15
Parwanipur	-2.9	14.8	9.2	18	71	19	17	12	25	46	42	38
Prasauni	9.6	7.1	17.4	23.4	78	12	12	16	17	52	43	29
Bishrampur	6.5	2.6	6.3	20.3	82	22	20	12	28	54	48	30
Pheta	22.3	10.2	27.9	29.9	77	12	12	11	22	46	42	24
Kalaiya	14.5	5.2	13.1	14.5	74	-1	-1	-7	15	39	35	5
Karaiyamai	4.3	0.14	7.8	12.8	83	22	23	17	43	59	55	41
Baragadhi	9.6	3.6	12.7	14.7	82	24	23	11	37	61	48	36
Adarsha Kotwal	1.8	0.38	12.4	20.9	74	10	9	5	25	37	40	15
Simroungadh	-0.62	17.9	23.7	32.1	75	1	6	5	18	41	42	14
Pacharauta	2.1	2.7	11.8	5	75	15	16	10	19	48	43	26
Mahagadhimai	9.4	12.4	20.1	18.1	81	22	22	14	23	54	46	32
Devtal	8.3	-1.1	16.3	18.5	82	15	17	14	25	54	51	32
Subarna	6.6	2.4	15.7	28.6	81	17	15	4	21	52	52	28
Parsa	16.3	8.3	13	17.1	74	18	19	10	21	43	45	36
Thori	-22.2	5.5	-2.4	21.9	82	13	17	7	9	44	33	33
Jirabhawani	6.9	11.8	14.3	14.1	84	24	30	15	30	54	55	33
Jagarnathpur	6.3	10.3	10.1	28.2	80	20	20	15	27	53	48	35
Paterwa Sugauli	18.9	8.1	18.3	23.7	79	25	40	7	24	49	44	47
Sakhuwa Prasauni	4.2	0.6	8.3	2.9	71	17	17	5	13	39	34	24
Parsagadhi	9.1	2	5.2	14.5	79	24	27	16	26	45	43	46
Birgunj	25.3	9.4	13.8	14.4	62	13	14	7	17	30	31	32
Bahudarmai	18.7	12.9	14.3	25.2	77	20	17	16	31	50	46	43
Pokhariya	3.6	4	12.4	8.7	79	16	17	8	24	51	40	30
Kalikamai	9.7	6.2	5.6	10.6	83	20	18	11	17	49	39	39
Dhobini	13.5	10.3	22.9	36.8	82	24	23	13	26	59	53	32
Chhipaharmai	11.2	18.2	25.7	32.7	82	25	24	20	28	58	57	42
Pakaha Mainapur	0.23	3.8	8.6	26.4	84	24	26	9	27	55	84	41
Bindabasini	12.8	5.9	15.1	14.7	77	16	17	6	14	45	41	35

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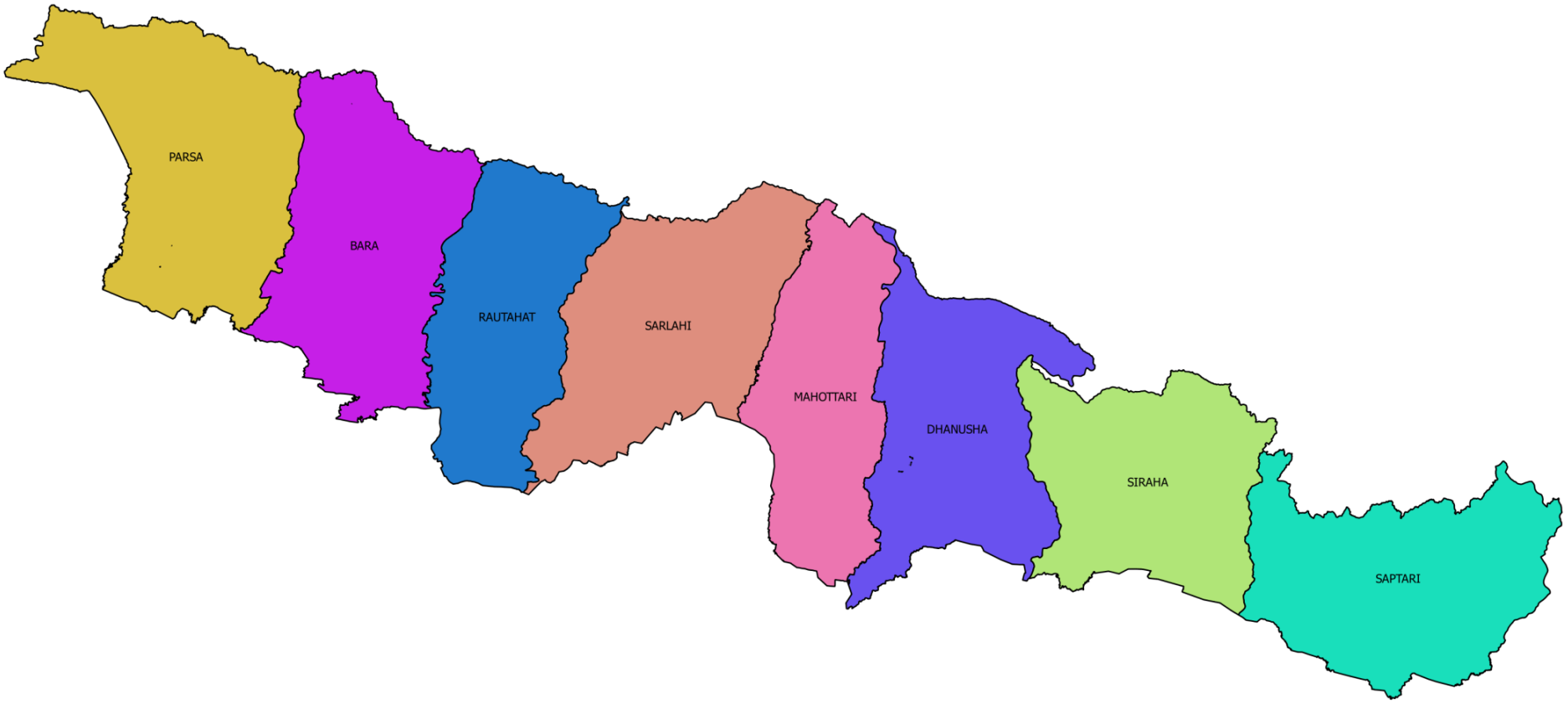
Map of Province No. 2, Nepal



Source : HMIS/MD, DoHS, Teku