District Annual Health Report
2080/081

Government of Karnali Province

Ministry of Social Development

Health Service Directorate

Health Service Office

Dailekh, Nepal

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Health Service Office Dailekh

Message

Date: 29th Asoj, 2081

The constitutionally guaranteed right to free primary healthcare is a fundamental right of every citizen, and it is the state's responsibility to ensure quality health services. The Health Service Office of Dailekh has consistently maximized its resources, significantly improving the health of its citizens, as shown by past performance evaluations.

The health workers of Dailekh has maintained morale and worked cohesively to ensure the delivery of essential services, reducing both incidence and mortality rates. Despite limited resources, the district has made notable progress, and the Karnali Province Health Directorate has pledged to support its future strategic plans.

As the Health Service Office prepares to publish its annual health report for fiscal year 2080/081, reviewing implemented programs, I believe that continued collaboration between federal, provincial, and local governments will further strengthen health services. This report serves as a bridge between past achievements and future goals, and I hope it helps address both strengths and challenges. Lastly, I would like to express my heartfelt gratitude to all those involved in the preparation of this report.

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Foreword

Date: 29th Asoj, 2081

A nation's progress relies on the health of its citizens, and coordination among federal, provincial, and local governments is key to delivering preventive, promotive, and curative healthcare. Following Karnali Province's integrated health system, the Health Service Office, Dailekh, has been advancing modern and emergency medical practices, with a commitment to coordinated health policies across all 11 local levels.

This FY 2080/81 report provides an overview of Dailekh's health services, highlighting contributions from the District Hospital, health institutions, FCHVs, and NGOs. While home delivery rates have dropped, basic service coverage has improved, though targets for TB and HIV prevention remain unmet. Maternal health indicators show progress, but service quality in birthing centers needs improvement. The rise in non-communicable diseases, mental health issues, and suicide rates underscores the need for effective programs and better diagnosis.

I extend my gratitude to the MoHP, Karnali Province government, Health Services Directorate, PHLMC and local governments, healthcare workers, FCHVs, NGOs, and journalists for their collaboration. Special thanks to the immediate past health service manager Dr. Dharma Raj Regmi for strengthening clinical and prevention part of Dailekh district, Health Service Office section chiefs and supporting organizations for contributing to this report's preparation and publication.

प्रा. स्वास्थ्य सेवा व्यवस्थापक

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Acronyms

ABER	Annual Blood Examination Rate
ADR	Adverse Drug Reaction
AGE	Acute Gastroenteritis
AHW	Auxiliary Health Worker
AIDS	Acquired Immunity Deficiency Syndrome
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infection
ART	Antiretroviral Therapy
ASL	Authorized Stock Level
BCC	Behavior Change Communication
BCG	Bacillus Calmette-Guérin
BEONC	Basic Emergency Obstetric and Neonatal Care
BHSC	Basic Health Service Centre
BPP	Birth Preparedness Package
BS	Bikram Sambat
CB-IMNCI	Community Based Integrated Management of Childhood Illness
CBO	Community Based Organization
CCC	Community Care Centre
CEONC	Community Care Centre
CHBC	Community Home Based Care
CHU	Community Health Unit
CHX	Chlorohexidine
CNR	Case Notification Rate
CNSI	Comprehensive Nutrition Specific Intevention
COPD	Chronic Obstructive Pulmonary Disease
CYP	Couple year of protection
DCC	District Coordination Committee
DDA	Department of Drug Administration
DH	District Hospital
DHIS	District Health Information Software
DoHS	Department of Health Services

DOTS	Directly Observed Treatment Short Course
DPT	Diphtheria, Pertussis, and Tetanus
eHMIS	Electronic Health Management Information System
HER	Electronic Health Record
EOC	Emergency Obstetric Care
EOP	Emergency Order Point
EPI	Expanded Program of Immunization
FB-IMNCI	Facility Based Integrated Management of Childhood Illness
FCHV	Female Community Health Volunteer
FIPV	Fractional Dose Inactivated Polio Vaccine
FY	Fiscal year
GBV	Gender Based Violence
HA	Health Assistant
HF	Health Facility
HFOMC	Health Facility Operation Management Comittee
HMIS	Health Management Information System
HIV	Human Immunodeficiency Virus
HP	Health Post
HPMSS	Health Post Minimum Service Standard
HSD	Health Service Directorate
HSO	Health Service Office
HTC	HIV Testing and Counselling
HW	Health Worker
IEC	Information Education and Communication
IFA	Iron Folic Acid
IPD	Inpatient Department
IUCD	Intrauterine Contraceptive Device
JE	Japanese Encephalitis
KMC	Kangaroo Mother Service
LLG	Local Level Government
MA	Medical Abortion
MDG	Millennium Development Goals
MDGP	Doctor of Medicine in General Practice
MAM	Moderate Acute Malnutrition

MDR	Multiple Drug Resistance
MGM	Mothers Group Meeting
MMR	Maternal Mortality Ratio
MNH	Maternal and Newborn Health
MoSD	Ministry of Social Development
MPDSR	Maternal and Perinatal Death Surveillance and Response
MR	Measles Rubella
MUAC	Mid Upper Arm Circumference
NCDs	Non-Communicable Disease
NENAP	Nepal's Every Newborn Action Plan
NMSP	Nepal Malaria Strategic Plan
NRH	Nutrition Rehabilitation Home
NTP	National Tuberculosis Program
OHW	One Heart Worldwide
OPD	Out Patient Department
OPV	Oral Polio Vaccine
ORC	Outreach Clinic
ORS	Oral Rehydration Solution
OTC	Outpatient Therapeutic Center
PAC	Post Abortion Care
PHA	Public Health Analytics
PHC	Primary Health Care
PHCC	Primary Health Care Centre
PHLMC	Province Health Logistics Management Centre
PHN	Public Health Nurse
PKDL	Post-Kala-azar Dermal Leishmaniasis
PMTCT	Prevention of Mother to Child Transmission
PNC	Post Natal Care
PPFP	Post Partum Family Planning
PSBI	Possible Severe Bacterial Infection
QGIS	Quantum Geographical Information System
RDQA	Routine Data Quality Assessment
RH	Reproductive Health
RM	Rural Municipality

RTI	Respiratory Tract Infection
RUSG	Rural Ultra Sound Sonography test
SAM	Severe Acute Malnutirion
SBA	Skilled Birth Attendee
SDG	Sustainable Development Goal
SHP	Skilled Health Professional
SMNHS	Strengthening Maternal and Neonatal Health Service
SRHR	Sexual and Reproductive Health and Rights
STDs	Sexually Transmitted diseases
STIs	Sexually Transmitted Infections
SWOT	Strength Weakness Opportunity Threat
TB	Tuberculosis
TD	Tetanus and Diphtheria
TCV	Typhoid Conjugate Vaccine
ToT	Training of Trainers
UHC	Universal Health Coverage
UM	Urban Municipality
UN	United Nation
UNGA	United Nation General Assembly
VDC	Village Development Committee
VIA	Visual Inspection with Acetic acid
VSC	Voluntary Surgical Contraception
WHO	World Health Organization

National Health Policy 2076

The constitution of Nepal has established basic health care as a fundamental right of its citizens. As the country has moved to a federal governance system, it is the responsibility of the state to ensure the access to quality health services for all citizens based on contextual norms of the federal system. This National Health Policy, 2019 has been formulated based on the lists of exclusive and concurrent powers and functions of federal, state and local levels as per the constitution. Also amalgamated with reference to the policies and program of the Government of Nepal; the international commitments made by Nepal at different times; and the problems, challenges, available resources and evidence in the health sector

Vision

Healthy, alert and conscious citizens oriented to happy life.

Mission

To ensure the fundamental health rights of citizens through optimum and effective use of resources, collaboration and partnerships

Goal

To develop and expand a health system for all citizens in the federal structures based on social justice and good governance and ensure access to and utilization of quality health services

Objectives

- To create opportunities for all citizens to use their constitutional rights to health;
- To develop, expand and improve all types of health systems as per the federal structure;
- To improve the quality of health services delivered by health institutions of all levels and to ensure easy access to those services;
- To strengthen social health protection system by integrating the most marginalized sections;
- To promote multi-sectoral partnership and collaboration between governmental, non-governmental and private sectors and to promote community involvement; and
- To transform the health sector from profit-orientation to service-orientation.

Policies

1. Free basic health services shall be ensured from health institutions of all levels as specified;

2. Specialized services shall be made easily accessible through health insurance;
3. Access to basic emergency health services shall be ensured for all citizens;
4. Health system shall be restructured, improved, developed and expanded at federal, state and local levels as per the federal structure;
5. In accordance with the concept of universal health coverage, promotional, preventive, curative, rehabilitative and palliative services shall be developed and expanded in an integrated manner.
6. Collaboration and partnerships among governmental, non-governmental and private sectors shall be promoted, managed and regulated in the health sector and private, internal and external investments in health education, services and researches shall be encouraged and protected;
7. Ayurveda, naturopathy, Yoga and homeopathy shall be developed and expanded in an integrated way.
8. In order to make health services accessible, effective and qualitative, skilled health human resources shall be developed and expanded according to the size of population, topography and federal structure, hence managing health services.
9. Structures of Health Professional Councils shall be developed, expanded and improved to make health services provided by individuals and institutions effective, accountable and qualitative
10. Domestic production of quality drugs and technological health materials shall be promoted and their access and proper utilization shall be ensured through regulation and management of efficient production, supply, storage and distribution.
11. Integrated preparedness and response measures shall be adopted to combat communicable diseases, insect borne and animal-borne diseases, problems related with climate change, other diseases, epidemics and disasters.
12. Individuals, families, societies and concerned agencies shall be made responsible for prevention and control of non-communicable diseases and integrated health system shall be developed and expanded.
13. In order to improve nutritional situation, adulterated and harmful foods shall be discouraged and promotion, production, use and access to qualitative and healthy foods shall be expanded
14. Health researches shall be made of international standards and the findings and facts of such reports shall be effectively used in policy formulation, planning and health system development.

15. The health management information system shall be made modern, qualitative and technology-friendly and integrated health information system shall be developed.
16. Right to information related to health and right of a beneficiary to know about the treatment shall be ensured.
17. Mental health, oral, eye, ENT (ear, nose and throat) health services shall be developed and expanded.
18. Quality of health services provided by all health institutions including hospitals shall be ensured.
19. Good governance and improvement shall be ensured in policy-related, institutional and managerial structures in the health sector through timely amendments.
20. In accordance with the concept of health across the lifecycle, health services around safe motherhood, child health, adolescence and reproductive health, adult and senior citizen shall be developed and expanded.
21. Necessary financial resources and special fund shall be arranged for sustainable development of the health sector.
22. Urbanization, internal and external migration shall be managed and public health problems associated with such phenomena shall be resolved.
23. Demographic statistics shall be managed, researched and analyzed to link them with the policy decisions and program designing.
24. Antimicrobial resistance shall be reduced, one-door health policy shall be developed and expanded for the control and management of communicable diseases, environmental pollution such as air pollution, sound pollution and water pollution shall be scientifically regulated and controlled.
25. Necessary arrangements shall be made to reduce the risks of immigration process on public health and to provide health protection to Nepalese staying abroad.

Sustainable Development Goals (SDGs)

The 2030 Sustainable Development Goals (SDGs) – a set of 17 Goals, 169 targets and 230+ indicators for achievement by 2030; Nepal one of the 193 signatory nations. SDGs aspire for eradication of poverty, zero hunger, good health and well-being, quality education, gender equality, clean water, energy & environment, 'good' growth & jobs, peace & justice among others.

Sustainable Development has been a global agenda since the last 25 years. The Millennium Development Goals (MDGs) based on Millennium Declaration in the year 2000 by the United Nations (UN) has set foundation for Sustainable Development Goals (SDGs) to be achieved by 2030. The UN Conference on Sustainable Development held in Rio de Janeiro in June 2012, and UN General Assembly (UNGA) held in September 2014 prepared solid foundation for SDGs and finally agreed in the UNGA held in September2015. Nepal, as a member of the UN, is a part of this global initiative. Sustainable development continues to be in-built in Nepal's socio-economic development. Nepal's efforts for the successful implementation of the MDGs have also opened new avenues for the implementation of SDG planned for 2016-2030.

Sustainable Development Goals

Goal 1 End poverty in all its forms everywhere

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

Goal 3 Ensure healthy lives and promote well-being for all at all ages

Goal 4 Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all

Goal 5 Achieve gender equality and empower all women and girls

Goal 6 Ensure availability and sustainable management of water and sanitation for all

Goal 7 Ensure access to affordable, reliable, sustainable and modern energy for all

Goal 8 Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all

Goal 9 Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation

Goal 10 Reduce inequality within and among countries

Goal 11 Make cities and human settlements inclusive, safe, resilient and sustainable

Goal 12 Ensure sustainable consumption and production patterns

Goal 13 Take urgent action to combat climate change and its impacts*

Goal 14 Conserve and sustainably use the oceans, seas and marine resources for sustainable development

Goal 15 Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss

Goal 16 Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels

Goal 17 Strengthen the means of implementation and revitalize the global partnership for sustainable development.

Nepal, despite being engulfed in a decadelong armed conflict during the initial years of Millennium Development Goals (MDG) implementation, has achieved significant progress on most MDG targets. Some targets have been met in advance and others have been met within the 2015 deadline.

Substantial progress has been made in child health with the MDG targets on infant mortality and under-five mortality already being met and rates of malnutrition substantially decreased. The MDG for reducing maternal mortality is also on track. The increase of HIV/AIDS prevalence has been halted and reversed, and prevalence and death rates associated with tuberculosis (TB) have declined markedly. Malaria remains under control.

However, the overall MDG achievements mask the disparities in outcomes by gender, social group, and geography. Also, the social focus of development spending of the government has resulted in under-investment in the economic sector which is undermining the progress in physical infrastructure and in turn constraining economic growth. Besides, the governance deficit continues for effective service delivery particularly at subnational and local levels. Completing the

unfinished MDG tasks and overcoming the disparities in the achieved outcomes and governance challenges need to be built in to the proposed SDGs and their strategies.

The proposed specific targets for SDG 1:

i. End all forms of malnutrition.

The proposed specific targets for SDG 2:

(i) Reduce the prevalence of undernourishment (measure of sufficiency of access to food at country level).
(ii) Reduce the prevalence of underweight children under-five years of age.
(iii) Reduce the proportion of households with inadequate food consumption (food consumption score).
(iv) Reduce the prevalence of anemia among women of reproductive age and children to less than one percent each.
(v) Increase the food grain production by at least 50 percent from the current level

The proposed specific targets for SDG 3:

(i) Reduce the MMR to less than 70 per 100 thousand live births.
(ii) Reduce preventable deaths of newborn and children to less than 1 percent.
(iii) Eliminate HIV, TB and malaria and other tropical diseases, and water borne diseases by 2030.
(iv) Reduce NCDs by one-third.
(v) Increase the CPR (modern methods) to 75 percent.
(vi) Raises the proportion of births attended by SBAs to 90 percent.
(vii) Increase institutional deliveries to 90 percent and provide post-natal care for 90 percent of mothers

SUMMARY FACT SHEET

SN	Program Indicators	2078/079	2079/80	2080/81
	Reporting Status (%)			
1	% of HMIS Reporting Status	100	100	100
2	% of HMIS On Time Reporting Status	78.6	91.7	97.1
3	% of LMIS Reporting Status	100	100	100
4	% of PHC/ORC Reporting Status	90.7	90.3	95.3
5	% of EPIC Reporting Status	96.7	91.7	95.4
6	% of FCHV Reporting Status	97.8	97.5	97.3
	Average no. of People served			
1	PHC/ORC (Per clinic)	19.9	18.2	17.7
2	EPIC (Per clinic)	15.6	13.7	11.9
3	FCHV (reporting period)	17.3	19.7	19.7
	National Immunization Program			
1	BCG Coverage	82.7	75.5	66.4
2	DPT-HepB-Bib1 Coverage	94.1	82.9	75.8
3	DPT-HepB-Bib3 Coverage	98	81.3	77.1
4	Measles-1 Coverage	97.1	80	77.1
5	Measles-2 Coverage	84.7	85.2	76.2
6	JE Coverage	94.1	82	77
7	TD2 & TD2+ Coverage	60.6	57.9	55.4
8	Full Immunization Coverage	-	84.9	75.4
9	Drop Out rate (DPT I Vs MRII)	10.7	-2.3	0.8
10	Number of children who started immunization after 24 months	-	67	27
	Nutrition Program			
1	Children aged 0-23 months registered for growth monitoring	90.3	59	49.5
2	Average number of visits among children aged 0-23 months registered for growth monitoring		8.6	10.6
3	Percentage of newborns with low birth weight (<2.5kg) among total delivery by HWs	6.7	6.5	7.1

SN	Program Indicators	2078/079	2079/80	2080/81
4	% of children aged 0-23 months registered for Growth Monitoring (New) who were Underweight	4.4	3.2	2.9
5	% of women who received a 180 days' supply of Iron Folic Acid during pregnancy	68.9	65.9	51.2
6	% of Postpartum Women who received Vitamin A		99.7	99.4
7	% of children below 6 months exclusively breastfed among registered for growth monitoring	71.1	79.6	76.5
	CB-IMNCI Program			
1	% of PSBI among registered 0-2 months infant (sick baby)	21.2	14.4	8.4
2	% of PSBI cases received complete dose of Gentamicin	71.1	68.4	55.3
3	Incidence of ARI among children under five years (per 1000)	375.2	321.7	333.3
4	Incidence of pneumonia among children under five years (per 1000)	57.6	48.7	44.4
5	% of pneumonia cases treated with antibiotics (HF & ORC)	96.5	98.1	96.4
6	Diarrhea incidence rate among children under five years	193.3	194	182.4
7	% of children under five years with diarrhea treated with zinc and ORS	93.3	94.1	98.6
8	% of newborns applied chlorhexidine (CHX) gel immediately among reported live birth	99.6	99.3	99.5
	Safe Motherhood Program			
1	% of pregnant women who had at least one ANC checkup	100.4	93.7	82.7
2	4 times ANC visits as % of per protocol	71.2	73.4	55.2
3	% of institutional delivery among expected live birth	63	74.7	62.6
4	% of women who had 3 PNC check-ups as per protocol (1st within 24 hours, 2nd within 72 hours and 3rd within 7 days of delivery)	0	47.6	45.7
5	% of delivery conducted by other than SBA/SHP	14.8	11.8	10.6
6	No. of Home Delivery	173	112	86
7	% of deliveries below 20 years of age among total institutional deliveries	0	20.4	21
8	Total still birth	61	52	45

SN	Program Indicators	2078/079	2079/80	2080/81
9	Number of preterm deliveries		45	59
10	% of institutional delivery among expected live birth	92.1	78.1	74.8
11	No. of PAC services provided	485	645	730
12	Number of C/S deliveries	99	132	144
13	No. of maternal death	5	3	0
14	No. of neonatal death	19	25	15
	Family Planning Program			
1	No. of IUCD service sites (functional)	20	19	16
2	No. of Implant service sites (functional)	33	30	39
3	CPR (Unadjusted)	23.8	28.7	29.4
4	FP new acceptors as %	10.7	7.9	8.5
	FCHV Program			
1	Number of FCHV	821	820	820
2	Percentage of mother group meeting conducted by FCHV	109.2	92.8	93.4
	Tuberculosis Control Program			
1	TB - Case notification rate (all forms of TB)	66.9	62.3	77.3
2	Total number of new TB cases	157	146	167
3	Treatment success rate	92.6	94.1	96.3
	Leprosy Control Program			
1	Incidence of leprosy per 10,000 population	0.24	0.35	0.24
2	Total number of new leprosy cases	6	9	6
3	Percentage of new leprosy cases presenting with a grade-2 disability	0	0	0
	Malaria Control Program			
1	Total malaria examination	371	1728	2497
2	No. of confirmed malaria cases	3	2	2
3	Reported death due to malaria	0	0	0
	Rabies			
1	Number of persons treated for animal bite	158	180	371
2	Number of deaths due to rabies	0	0	0

SN	Program Indicators	2078/079	2079/80	2080/81
	Snake Bite			
1	Number of persons treated for snake bite	13	42	52
2	Number of deaths due to snake bite	0	0	0
	HIV/AIDS Program			
1	No of women tested for HIV(PMTCT)	4583	5621	4731
2	No of people tested for HIV(HTC)	1227	773	383
3	No of reported HIV +ve case (New) (PMTCT+HTC)	1	5	8
4	No. of Persons Receiving ART	203	215	222
	OPD Service			
1	Total new OPD visit	221818	178680	173997
2	Total new OPD visit as % of total population			
	District Hospital Information			
1	Total Number of OPD case	10873	8032	11879
2	Total Number of emergency case	2621	3229	3694
3	Number of sanctioned beds	15	15	15
4	Number of available beds	52	50	54
5	Average length of stay in hospital	3.1	3.3	2.3
7	Bed occupancy rate	31.2	24	18
	Reproductive Health Morbidity			
1	Cervical cancer screened through VIA	-	1230	1001
2	Positive cervical cancer patients (through VIA)	-	14	38
3	No. of women screened for breast cancer	-	435	556
4	Breast cancer Suspected cases	-	3	3
5	No. of women screened for uterine prolapse	-	1039	1030
6	No. of prolapse cases	-	306	358
7	Number of uterine prolapse cases undergone surgery	-	8	1
	Minimum Service Standard			
1	Total MSS conducted health facility		54	59
2	White category		3	2
3	Yellow category		27	44

SN	Program Indicators	2078/079	2079/80	2080/81
4	Blue category		19	11
5	Green category		5	2

Executive Summary

This District Annual Health Report of Health Service Office of fiscal year 2080/2081 (2023/2024) reflects the performance of different programs over the preceding three fiscal years and presents problems/constraints actions taken against them and suggested actions for further improvement. Health service information on its progress and achievement of health institutions of local levels, district aligning with national service coverage have been presented and analyzed comparatively in this report.

This report is mainly based on information collected by DoHS's Health Management Information System (HMIS) from Dailekh District Hospital to peripheral health facilities. A total of 6 Hospital (District hospital, Dullu hospital, Aathabis basic hospital, Gurans basic hospital, Bhagwatimai basic hospital and Mahabu basic hospital), 2 Primary Health Care Centers (PHCCs), 54 Health Posts (HPs) reported to HMIS in 2080/2081. This report also includes service coverage by 208 Primary Health Care/Outreach Clinics (PHC/ORC), 260 Expanded Programmed of Immunization (EPI) clinics and 820 Female Community Health Volunteers (FCHVs), 20 Community Health Units, 31 Basic Health Service Center, 14 Urban Health Centers. District Karagar also reported to HMIS this year.

Major programs implemented in the district were Expanded Program on Immunization, Nutrition program, IMNCI, Family Planning, Maternal & Newborn Health, FCHV program, PHC/ORC program, TB control program, Malaria, Kala-azar, Leprosy Elimination Program, Reproductive Health, HIV/AIDS prevention and control program.

Reporting status of hospitals, PHC & HP was 100 percent each. Similarly, 100 percent of urban health center, 100 percent of community health units, Basic Health Service Center. A total of 95.3% percent PHCORC and 95.3% EPI clinics were conducted and reported in 2079/2080. A total of 97.3% of FCHVs and 100 percent of NGO reported in 2080/2081. The HIMS and LMIS reporting in last fiscal year was 100 percent. Completeness and timeliness of reporting from public facilities & regular report from non-public health facilities to HMIS has increased compared to previous fiscal years. Timely reporting has been increased from 91.7% in 2079/80 to 97.1% in 2080/81.

IMMUNIZATION

Dailekh district was declared fully immunized district on 4th Ashad 2074. The district immunization coverage of most of the antigens in the regular National Immunization Program (NIP) during fiscal year coverage of Dailekh district for all vaccine was found in decreasing trends with <90% coverage for major antigens. In 2080/81 a total of 66.4% of the target children were immunized with BCG, 75.8% with DPT/HepB/HiB I, 77.1% with DPT/HepB/HiB II. A total of 75.4% of children were fully immunized within 23 months. A total of 27 children started immunization after 24 months. 55.4% of the pregnant women were immunized by TD2/TD2+. The dropout rate for DPT/HepB/HiB I Vs MR II was 0.8%. Among the 11 local levels of the district, two municipalities (Naumule and Narayan) fell under category I and all other local level fall under category III.

NUTRITION

A total of 49.5% of children aged 0-23 months were registered for growth monitoring program. Among the children coming for first visit for growth monitoring, 2.9% of children were underweight. Children who completed 23 months registered for growth monitoring came for growth monitoring for an average of 10.6 times. A total of 7.1% of children were born underweight. Three in four children i.e., 76.5% were exclusively breastfed for 6 months. 51.2% of the women received 180 iron tablets and 16.4% of the women received calcium tablets. 99.4% of the delivering mother got Vitamin A supplementation.

INTEGRATED MANAGEMENT OF NEONATAL AND CHILDHOOD ILLNESS (IMNCI)

The CB-IMNCI program has been rolled out to all municipalities of district which aim to reduce neonatal and child mortality. The IMNCI program has been implemented up to community level and it has shown positive results in management of neonatal & childhood illnesses. The incidence rate of pneumonia was 44.4 per thousand and 96.4% of children suffering from pneumonia were treated with amoxicillin. There was a slight increase in incidence of acute respiratory infection from 321.7 per thousand in 2079-80 to 333.3. The incidence rate of diarrhea was 182.4 and a total of 98.6% of the children suffering from diarrhea were treated with Zinc and ORS.

FAMILY PLANNING

The Contraceptive prevalence rate (CPR) for modern methods was 29.4% in the district. New user rate for contraception was 8.5%. Among the total contraceptive user, majority of the users i.e., 53.4% of the users were using temporary method of family planning. Among the temporary users of the contraceptive, Implant (38.9%) followed by Depo (34.3%) was the most used method of contraceptive in Dailekh district.

SAFE MOTHERHOOD

There was a total of 81 birthing center, 2 BEONC and 2 CEONC sites in Dailekh district in 2080/81. A total 3590 live birth were delivered during this fiscal year which is a surprisingly lower than the last years 4225 delivery while there was a total of 0.8% stillbirth and 59 preterm deliveries. Among total delivery 83 children were delivered in home. Three in five i.e., 62.6% delivered their children in the health facility. A total of 55.2% of women had four ANC visits as per the protocol and only 35% of the women had eight ANC visits as per the protocol. Among the total delivery, 144 C/S were done. A total of 44.2% of women had four post-natal checkups as per protocol. No maternal death occurred in Dailekh districts this year.

FEMALE COMMUNITY HEALTH VOLUNTEER (FCHV)

A total of 820 Female Community Health Volunteers (FCHVs) are working in Dailekh and are involved in the promotion of safe motherhood, child health, family planning, and other community-based health services to promote health and healthy behavior of mothers and community people with support from health workers and health facilities. 93.4% of mother group meeting conducted by FCHV in fiscal year 2080/081. A total of 20 persons were served by FCHV per month. A total of 66,979 times MUAC was screened for children. Besides, they were also actively involved support on regular priority health programs, national campaign events, as counseling and referring mothers to the health facilities for the service utilization.

PRIMARY HEALTH CARE OUTREACH CLINIC (PHC/ORC)

There are a total of 208 PHC/ORCs in HMIS reporting system.95.3 % of the PHC/ORC were conducted this year with an average number of people served being 17.7.

MALARIA

A total of 2497 malaria examination was done this year, out of which 2 cases were positive, both being imported. No malaria related death was reported in 2080/81.

FILARIAS

No cases of filariasis were reported in Dailekh district in 2080/81.

TUBERCULOSIS

Treatment by Directly Observed Treatment Short Course (DOTS) for Tuberculosis (TB) is being in district through 64 treatment centers. 4 MDR sub center (Dailekh and Dullu hospital, Lakandra and Naumule PHC). The Case Notification Rate (CNR) was 77.3 per 100,000 in fiscal year 2080/081. A total of 167 TB cases were reported in the year. The treatment success rate of TB was 96.3%.

LEPROSY

A total of 6 new cases were reported in 2080/81 making an incidence rate of 0.24 per 10,000 cases. No leprosy cases presented grade-2 disability.

HIV/AIDS AND STI

HIV exists as a public health problem in Dailekh. There are 4 HTC centers, 2 ART site, 1 ART dispensing site (Dullu Hospital) and 0 functional CD4 count center (District Hospital). 4 HTC

centers (DH, Dullu, Naumule, Lakandra), 1 ART dispensing site and CD4 center were established in district hospital, CCC and CHBC-1(Dailekh Plus), 60 PMTCT (All HFs). Aathbis, Dullu municipality, border of Accham district, share for more than half of HIV cases of district. 5621 pregnant women were tested for HIV/AIDS (PMTCT) and 383 other individuals were tested for HIV (HTC). A total of 8 new cases were reported this year making a total 222 persons receiving ART.

CURATIVE SERVICES

Curative services are provided through 6 hospital (2 Hospital, 4 Basic Hospital), 2 Primary Health Care Centers (PHCCs), 54 Health Posts (HPs), 20 Community Health Units, 31 Basic Health Service Center, 14 Urban Health Centers as well within the district. 70.4% of the total population had taken at OPD services. Health service office procured free essential medicine and also received from Province & Central store then supplied to all of Health facilities.

SUPPORTING PROGRAMS

HEALTH TRAINING

The overall goal of Health training is to develop capacity of health service providers to deliver quality health care services. Objective of health training is to produce skilled human resources. Health trainings are generally conducted as, in service, & specialized as onsite coaching which are targeted to all level health workers within the district.

In this fiscal year, series of training have been conducted in district such as Immunization Basic, micro planning training on Immunization, orientation on EPI & fully immunization to HFOMC/Palika Elected members, FB-IMNCI, CNSI, ToT of IMNCI Coacher, MNH update, MPDSR, HMIS/LMIS, NCD Package, RDQA orientation, DHIS2, revised HMIS training, QGIS training, LMIS and Public health analytics training etc.

HEATLH EDUCATION, INFORMATION AND COMMUNICATION

The health education information and communication program are one of the most important supporting health programs which is as old as the modern health services in Nepal. The general objective of the program is to raise the health awareness of the people to promote health status and to prevent disease through full utilization of available resources. Health Service Office implements IEC activities utilizing various methods and media according to the local needs of the people. Major activities conducted in this fiscal year includes distribution of IEC materials, airing of health radio programs and messages through local FM radio, health exhibition, publication of health messages in print media, Media person, community interaction program for health service promotion, IEC program on anti-tobacco, non-communicable diseases control and celebration of different health days.

LOGISTIC MANAGEMENT

Health Service Office's Store took responsibilities to store and distributes health commodities for the government health facilities and other facilities provided by LMD, PHLMC, HSD. It also involves in repairing and maintenance of instruments along with transport vehicles, Repacking and

supply of drugs, vaccines & key commodities including essential druges, HMIS/LMIS Tools and other items of regular program, Support to national campaigns. Overall, LMIS reporting stands at 100 percent in Dailekh district form Hospital, Basic Hospital, PHCs, HPs, Community Health Units, Basic Health Service Center, Urban Health Center& NGOs.

PLANNING, MONITORING, SUPERVISION AND INFORMATION MANAGEMENT

Data management committee of HSO coordinates with district HF and other NGOs for timely reporting and feedback. Major activities conducted by this section in fiscal year 2080/81 were done in District Semi/Annual Performance Review Meeting, Immunization review, MNH update, MPDSR, HMIS/LMIS, training for newly recruited health workers and construction and maintenance of Hospitals.

CHAPTER – I

INTRODUCTION OF DAILEKH DISTRICT

Dailekh district is a high, hilly region situated in the southern belt of Karnali Province. It lies 67 km north of Surkhet, the provincial capital of Karnali, and 650 km from the federal capital, Kathmandu. It is surrounded by Jajarkot in east, Achham in west, Kalikot in north and Surkhet in South.

In ancient times, this area was believed to be the land of the gods, known as "Daibalok," which later evolved into "Dailekh." During the 12th to 14th centuries, Dailekh was part of the Khasa Kingdom. Another mythological account suggests that the name Dailekh originated from the sage Dadhichi, with "Lekh" meaning hill.

Geography and Climate

Dailekh district spans an area of 1,502 square kilometers, making up 1.02% of Nepal's total land area. It is located between latitudes 28°35' N to 29°8' N and longitudes 81°25' E to 81°53' E. The district's lowest point is 544 meters at Tallo Dungeswor, while its highest elevation reaches 4,168 meters at Mahabu Lekh. The district headquarters, Dailekh Bazar, is situated at Devkota Chowk, with an elevation of 1,448 meters.

Eighty percent of Dailekh consists of hilly terrain, while the remaining 20% is characterized by high hills. The district experiences an average maximum temperature of 34°C and an average minimum of 5°C, with an annual rainfall of approximately 1,700 mm. Dailekh features four major climate zones: subtropical, upper tropical, temperate, and subalpine respectively.

Political and Administrative Divisions

Province: Karnali

District: Dailekh

District headquarter: Dailekh Bazar

Local level: 11 ; 4 urban and 7 rural municipality

Number of constituencies: 2 federal and 4 provincials

Number of wards: 90

Figure 1 Map of Dailekh District

Demographic Information

According to the census 2078 BS, the total population of the Dailekh was 2,52,313. The sex ratio of was 91.82 male per 100 females. The population density of was 168 and the population growth rate -0.35%.

Table 1 Demographic information of Dailekh

Total number of households	54,610
Total Population	2,52,313

Sex ratio (male per 100 females)	91.82
Population density	168
Annual population growth rate	-0.35%
Disability rate	3.2%
Literacy rate	75.5%
Proportion of household without own toilet	2.1%
Proportion of health facility with internet facility	11.8%
Average household size	4.6
Percentage of household headed by women	36.0%

Population Pyramid

The population pyramid of Dailekh illustrates a youthful demographic, with a large proportion of the population under the age of 30. This indicates a growing and potentially vibrant population. As age increases, the number of individuals in each age group decreases, suggesting a declining population in older cohorts over time. Notably, in the older age groups, there are more females than males, indicating that women tend to live longer than men in this region. Additionally, the gender imbalance, particularly in the younger age groups, could have significant social implications, potentially affecting family dynamics, workforce composition, and community development.

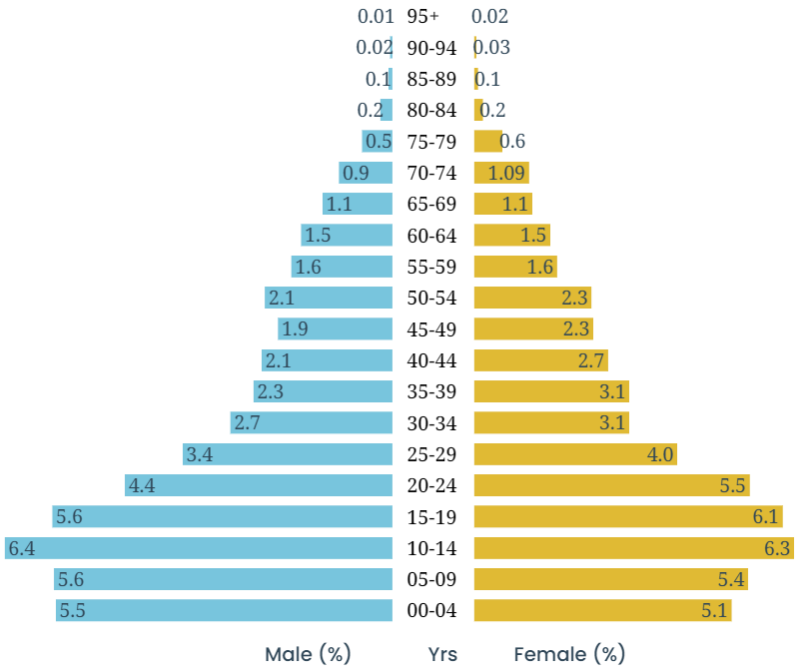


Figure 2 Population pyramid of Dailekh

Population Distribution by Municipalities

Dullu municipality has the highest number of households and highest number of populations in the district and while Dungeswor has the lowest number of household and total population in the district.

Table 2 Population distribution by municipalities

Local level name	Number of Household	Population		
		Male	Female	Total
Naumule	4223	9491	10,196	19,687
Mahabu	3968	8262	9797	18,059
Bhairabi	4269	8,584	10,183	18,787
Tantikandh	3840	8,930	9,371	18,301
Aathbis	6,134	15,250	15,842	31,092

Chamunda	5,113	13,021	13,538	26,559
Dullu	9,053	18,105	21,038	39,143
Narayan	6,504	12,205	13,906	26,111
Bhagawatimai	3,550	9,017	8,189	18,206
Dungeswor	3,399	6,890	7,643	14,533
Gurans	4,541	10,402	10,787	21,189

Population Distribution by Ethnicity

The major ethnicity of the Dailekh district is Chhetri (35.3%) followed by Bishowkarma (19.6%) and Thakuri (13.8%).

Table 3 Population distribution by ethnicity

Ethnicity	**Total Population (%)**
Chhetri	35.3
Bishowkarma	19.6
Thakuri	13.8
Brahmin-Hill	9.6
Magar	9.1
Pariyar	5.1
Mijar	3
Others	3

CHAPTER- II

DISTRICT HEALTH PROFILE

The Dailekh district was previously composed of 55 Village Development Committees (VDCs) and one municipality. After federalization in 2072, it was restructured into 11 municipalities: 4 urban and 7 rural. This decentralization significantly impacted the health system, which now operates under the health sections of the 11 municipalities.

Dailekh district has two hospitals: Dailekh District Hospital and Dullu Hospital. Additionally, there are four basic hospitals: Bhagawatimai, Gurans, Mahabu, and Rakam Karnali. Every one of the district's 90 wards has at least one health facility. Immunization services are provided through 260 Expanded Program on Immunization (EPI) clinics, while 208 outreach clinics are run in the district. The district also features 20 Outpatient Therapeutic Centers (OTCs) and one Nutrition Rehabilitation Home (NRH).

There are 81 birthing centers across the district, though only 47 meet established standards. Furthermore, the district hosts 64 Directly Observed Treatment, Short-Course (DOTS) centers, 5 microscopy sites, 1 GeneXpert site, 4 HIV testing and counselling (HTC) sites and 2 Antiretroviral Therapy (ART) site. Despite the presence of 18 laboratory sites, some are not optimally functional. A total of 18 ambulances are functional within the district.

Table 4 Description of service sites in Dailekh

Local level	11	BEONC site	2
Hospital/Basic Hospital	6	Safe abortion site	15
Private hospital	0	DOTS center	64
Private clinic/pharmacy	15	Microscopy site	5
Polyclinic	2	Gene-Xpert site	1
Primary Health Care Centre (PHCC)	2	HTC center	4
Health post	54	ART center	2
Basic health service center	31	CD4 site	0
Community health unit	20	OTC center	20

Urban health clinic	14	NRH Centre	1
Ayurvedic health center	1	Laboratory service	18
Ayurvedic aushadhalaya	11	FCHV number	820
Outreach clinic	208	Total functional ambulance	18
Extended program for immunization clinic	260	IUCD service sites	16
Birthing center	81	Implant service sites	39
Birthing center as standard	47	All 5-family planning service site	16
CEONC site	2	Rehabilitation service site	1

Health Infrastructure

Although every ward in Dailekh has a health facility, only 89 facilities are equipped with internet and computers, and just 79 have 24-hour electricity. While all wards have a stretcher, some facilities lack quality ones due to poor supply from the tendering process.

In addition, the Minimum Service Standards (MSS) assessment was conducted in 59 health facilities. Only two—Dandaparajul Health Post and the District Hospital—met the criteria for the green category, while Naulekatuwal and Kusapani Health Posts fell into the white category, indicating lower performance.

The delayed construction of the District Hospital has been a major concern. Although the project was originally scheduled for completion by Jestha 30, 2081, only 40% of the work had been finished by that deadline. Consequently, the contract has been extended until Bhadra 30, 2082.

MSS Category	Total health facility number (n=59)	Description
White	2	Naulekatuwal and Kusapani HP
Yellow	44	
Blue	11	
Green	2	Dandaparajul HP and District Hospital

Health facility with internet and computer	88
Health facility with 24-hour electricity supply	79

Human Workforce

In the Health Service Office Dailekh, health workers from the 4th to the 10th level are sanctioned. Out of 61 sanctioned positions, 39 are currently filled. However, most officer-level and higher positions remain vacant. Of the 16 sanctioned officer-level and above positions, only 5 are filled. Despite six consultant doctor positions being sanctioned, none are currently occupied. However, the Health Service Office does have a consultant MDGP on a scholarship bond, and two medical officers are providing consultant services.

Table 5 Human workforce in HSO Dailekh

Position	Sanctioned post	Fulfilled	Vacant	Contract/ Bonding
Health Service Manager (PHA/Consultant 9/10th)	1	0	1	0
Consultant Doctors (9/10th)	6	0	6	1
Medical Officer (8th)	5	4	1	5
Dental Surgeon (8th)	1	1	0	1
Public Health Officer (7/8th)	1	0	1	1
Radiotechnologist (7/8th)	1	0	1	0
Hospital Management Officer (7/8th)	0	0	0	1
Nursing Officer (7/8th)	0	0	0	2
Medical Lab technician(7/8th)	1	0	1	1
Public Health Nurse (5/6/7th)	1	1	0	0
Paramedics (5/6/7th)	3	4	0	0
Nursing (5/6/7th)	8	5	3	0
Statistics Officer	1	1	0	0

Paramedics (4/5/6th)	3	2	1	0
Cold chain Assistant (4/5/6th)	1	1	0	0
ANM (4/5/6th)	3	4	0	0
Other Technical (4/5/6/7th)	9	8	1	0
Administrative Assistant/Officer	1	1	0	0
Accountant	1	1	0	0
Helper/Driver	14	6	8	30
Total	61	39	24	42

Similar to the Health Service Office, most officer-level and higher positions remain vacant at the local level. Only Thantikandh and Naumule have permanent doctors, and none of the municipalities have a public health officer. Additionally, 76.8% of paramedic positions and 71.3% of nursing positions are filled across the district.

Table 6 Human workforce in local level

Position		**Local Level/ Organization Name**											
		Narayan	Dullu	Chamunda Bi.	Aathbis	Thantikandh	Bhairabi	Mahabu	Naumule	Bhagawatimai	Dungeswor	Gurans	Total
Consultant	Sanctioned	0	1	0	0	0	0	0	0	0	0	0	1
	Fulfilled	0	0	0	0	0	0	0	0	0	0	0	0
	Vacant	0	1	0	0	0	0	0	0	0	0	0	1
	Contract	0	0	0	0	0	0	0	0	0	0	0	0
Medical Officer	Sanctioned	0	2	0	1	1	0	1	1	1	0	1	8
	Fulfilled	0	0	0	0	1	0	0	1	0	0	0	2
	Vacant	0	2	0	1	0	0	1	0	1	0	1	6
	Contract	0	3	0	1	0	0	1	0	1	0	1	7

Public Health Officer	Sanctioned	1	1	1	1	0	0	0	0	0	0	0	4
	Fulfilled	0	0	0	0	0	0	0	0	0	0	0	0
	Vacant	1	1	1	1	0	0	0	0	0	0	0	4
	Contract	0	0	0	0	0	0	0	0	0	0	1	1
Paramedics (4/5/6/7th)	Sanctioned	28	33	16	20	20	10	16	23	22	15	30	233
	Fulfilled	20	26	8	16	11	14	17	20	13	15	19	179
	Vacant	8	7	8	4	9	0	0	3	9	0	11	54
	Contract	5	10	13	1	6	2	10	7	7	3	2	66
Nursing (4/5/6/7th)	Sanctioned	21	26	12	13	15	7	11	17	18	11	20	171
	Fulfilled	13	23	5	13	7	7	9	12	9	11	13	122
	Vacant	8	3	7	0	8	0	2	5	9	0	7	49
	Contract	10	16	9	0	14	7	15	10	8	6	19	114

Information Management

Health Information Management System (HMIS)

Health information data is recorded and reported as per the Health Management Information System tools. A total of 121 health facilities are registered in DHIS2 which includes a total of 107 public health facilities and 14 private health facilities.

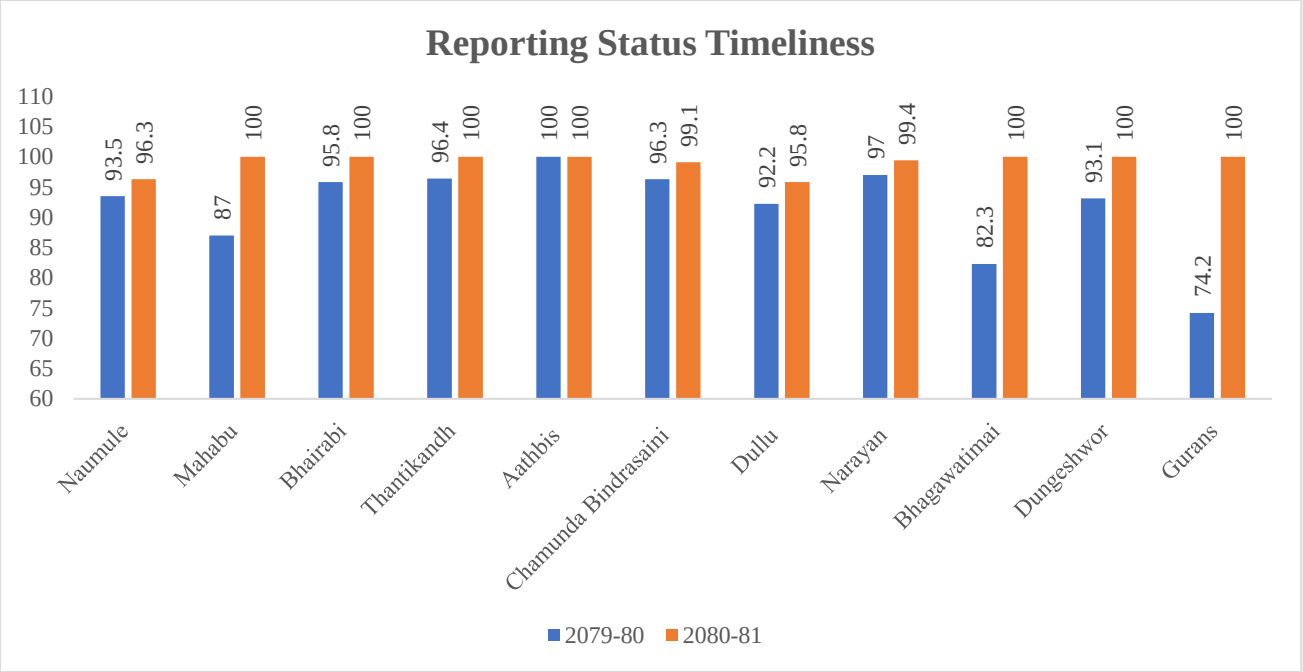


Figure 3 HMIS reporting status 2080-81

Situation Analysis

The timeliness of report submissions has improved over the past years, with the majority of health facilities submitting their reports on time. However, facilities in Dullu, Naumule, and Chamunda have experienced delays in their reporting.

Challenges

The majority of health facilities in the district are equipped with internet and computer facilities, allowing them to perform data entry independently. However, a few facilities lack these resources, which hinders timely reporting. Notably, some health facilities in Bhairabi rural municipality and Chamunda urban municipality are without internet access. Additionally, health facilities in Dullu sometimes lack a dedicated healthcare staff member, contributing to delays in reporting.

Furthermore, some health facilities in Bhairabi, Chamunda, Thantikandh, and Mahabu enter their data directly from the health section using their respective accounts. The absence of trained backup professionals has also posed challenges in ensuring timely and accurate data entry.

Activities

The Health Service Office conducted revised Health Management Information System (HMIS) training for newly recruited staff and performed Routine Data Quality Assessments (RDQA) and data verification programs in over 30 health facilities. Additionally, DHIS2 training was provided to staff at the health facility level.

Moreover, 11 groups were established for each municipality to facilitate feedback on data from the HSO team. Monthly online meetings were held, inviting all health professionals from the district to participate and discuss relevant issues on data.

Logistics Management Information System

Logistic Management

Logistic management is the systematic process of planning, implementing, and controlling the efficient, cost-effective flow and storage of pharmaceutical products, medical supplies, and equipment from the point of procurement to the point of distribution or use.

Objectives of logistic management

To plan and carry out the logistic activities for the uninterrupted supply of essential medicine, vaccine, contraceptives, equipment, HMIS/LMIS forms and allied commodities for the efficient delivery of health care services from the health institutions of government in the district.

Logistic management information system

Some important milestone and activity related to eLMIS development in Nepal.

Table 7 Milestones in LMIS

Fiscal Year	Milestone/ Activity	Details of Activity
2050/51 (1994)	Establishment of LMIS Unit	The LMIS unit is established under the Logistic Management Division.
2065/66	Introduction of Web-Based LMIS	Web-based LMIS started for better logistics management.
2073/74	Online-IMS (Inventory management system)	IMS implemented regarding store management.
Baisakh 2075	Expansion to eLMIS	Electronic Logistic Management System started to manage the supply chain more effectively.
Ashad 2080	eLMIS Coverage	32,570 live sites covering 2,539 SDPs, 753 LLGs, 77 Health Offices, Provincial, and Federal Stores.
2079/80	Reporting Cycle Change	The LMIS reporting was changed from quarterly to a monthly basis to track more frequently.
Ongoing	eLMIS Features, Digitization of Inventory Management	Dashboard on stock status, consumption, reporting, and data safety, Handover takeover form, supply registration, and stock books were digitized through eLMIS.

Logistic Management cycle

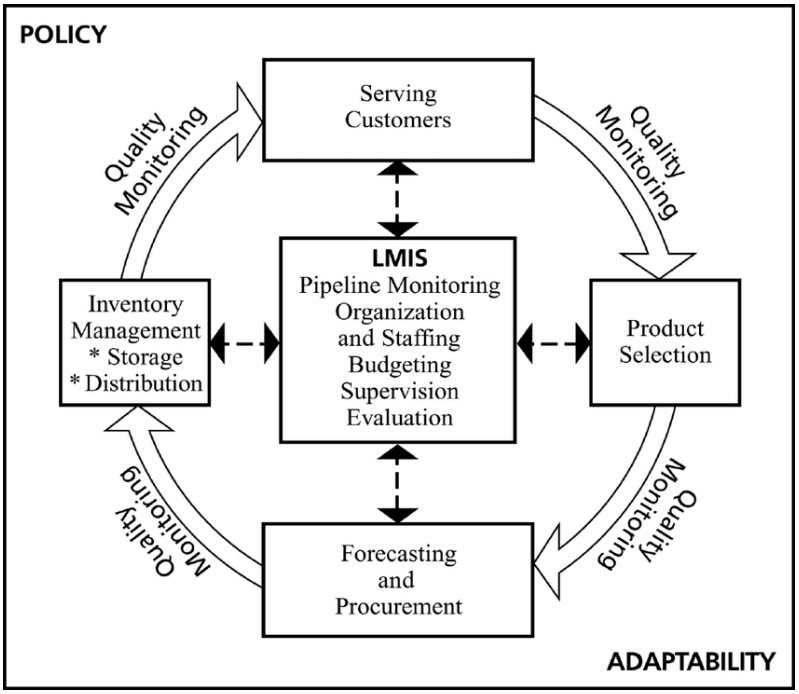


Figure 4 Logistics Management Cycle

SWOT analysis for the electronic Logistic Management Information System (eLMIS) in Nepal:

Table 8 LMIS SWOT Analysis

Strength	Weakness
Enhanced supply chain efficiency	Limited internet infrastructure in remote areas:
Real-Time data and stock Monitoring	System downtime
National coverage	Manual processes still in use
Opportunity	**Threat**
Expansion to all service delivery Points (sdps)	Infrastructure barriers
Improved training programs	Technological failures:
Enhanced data-driven decision making	Limited funding for ongoing system upgrades

Access to Essential Medicine

Table 9 Access to Essential Medicine

SN	Category	Description
1	Essential Medicines Program	Government of Nepal (Department of drug administration) prepare a list of essential medicines based on WHO standards to address common public health needs.
2	Total Free Essential Medicine	98 essential medicines including vaccines are provided free of charge at government health facilities all over the Country.
3	Procurement Authority	Department of Health Services (DoHS): Logistics Management Division (LMD) PHLMC, Local level
4	Public Procurement Process:	Conducted through competitive bidding in accordance with the Public Procurement Act 2063.

5	Quality Control Status	Department of Drug Administration (DDA): Regulates and ensures quality, safety, and efficacy of medicines.
6		Quality Assurance: Medicines must comply D11with DDA standards; procurement includes stringent quality criteria.
7		Good Manufacturing Practices (GMP): Guidelines that manufacturers must follow for product quality.
8		Post-Marketing Surveillance: DDA conducts random quality tests of medicines distributed in the market.
9		Pharmacovigilance Program: Enables reporting of adverse drug reactions (ADRs) for quality monitoring.
10	Challenges	Resource Constraints: Difficulty in monitoring remote health facilities effectively.
		Counterfeit and Substandard Drugs: Occasional reports of substandard drugs despite regulatory efforts.
		Decentralization: Ensuring uniform quality control standards across local level procurement remains challenging.

Some terms related to eLMIS

Bin Card: Used for real-time tracking of stock movements.

Emergency Order Point (EOP): Trigger point for placing emergency orders to avoid stockouts; calculated by using lead time demand and safety stock.

Emergency Order Point (EOP)=Lead Time Demand + Safety Stock

Authorized Stock Level (ASL): Maximum stock level allowed without extra approval; ASL is usually kept for 5 months. Determined by the reorder level and safety stock. Calculated by using following formula.

Monthly consumption= total yearly consumption /12

ASL = Monthly consumption X 5

Explain the flow of logistics in Dailekh from local level to the HFs. Explain about the ASL EOP types of medicine to be bought by each level of government. Under one section explain the cold chain management process

Electronic Health Record (EHR) and Electronic Health Management Information System (eHMIS)

An Electronic Health Record (EHR) is a digital system for collecting and retrieving patients' medical information. Since Chaitra 2078, the District Health Office and Hospital have adopted EHR systems. Rakam Karnali Basic Hospital and Sattala Health Post in Aathbis Municipality have been using the Electronic Health Management Information System (eHMIS) since Shrawan 2079. Additionally, Dullu started utilizing EHR in Shrawan 2081.

At Dailekh District Hospital, EHR is used across various departments, including registration, billing, OPD, pharmacy, laboratory, IPD, NRH, maternity ward, ANC, emergency, rehabilitation, and NRH. In contrast, Rakam Basic Hospital and Satalla Health Post limit their use of eHMIS to registration and OPD services.

Advantages

- Significant support for the Health Insurance program, especially in co-payment processing.
- Efficient tracking of patient history.
- Simplified data extraction with information available at the click of a button.
- Data can be leveraged for research purposes.

Challenges

- Insufficient computers and internet facilities disrupt the consistent use of eHMIS, particularly at health posts.
- Data entry can be time-consuming, causing delays in patient services, especially on busy OPD days.
- Outdated systems lead to inaccurate reports.
- Limited diagnostic options in the EHR system.
- Report submission is unreliable, and the integration process is not fully optimized.
- No dedicated focal person for EHR in the provincial level

- Lack of proper orientation to the Medical Recorders regarding EHR.

Status of Good Governance, Policy Documents, and Public Accountability

All local health facilities have developed key documents, including a local health act, health policy, Ambulance Service Operation Act, FCHV services and facilities protocol, contract employee management protocol, sanitary pad distribution protocol for adolescents and women of reproductive age, health facility operation standards guideline, disaster response plan, and rapid response team guidelines.

However, Naumule lacks a Health Sector Monitoring, Evaluation, and Supervision Guideline, and Bhairabi does not have a Health Program Operation Guideline. Additionally, five local levels are without a Waste Management Protocol, six lack a Municipal Hospital Operation and Management Protocol, and seven local levels are missing a Hospital Pharmacy Operation Guideline. Furthermore, only three municipalities have a Geriatric Home Visit Program Guideline and EOC Fund Operation Guidelines, and just two municipalities have a Procedure for the Health Insurance Program for Ultra-Poor Citizens.

Table 10 Status of Good Governance, Policy Documents, and Public Accountability

Description	Local Level Name											
	Narayan	Dullu	Chamunda	Aathbis	Thantikandh	Bhairabi	Mahabu	Naumule	Bhagawatima	Dungeswor	Gurans	Total
Local health Act	1	1	1	1	1	1	1	1	1	1	1	11
Health policy	1	1	1	1	1	1	1	1	1	1	1	11
Ambulance service operation act	1	1	1	1	1	1	1	1	1	1	1	11
FCHV services and facilities protocol	1	1	1	1	1	1	1	1	1	1	1	11
Contract employee management protocol	1	1	1	1	1	1	1	1	1	1	1	11

Sanitary pad distribution protocol for adolescent and reproductive aged women	1	1	1	1	1	1	1	1	1	1	1	11
Health facility operation standards guideline	1	1	1	1	1	1	1	1	1	1	1	11
Disaster response plan	1	1	1	1	1	1	1	1	1	1	1	11
Rapid response team	1	1	1	1	1	1	1	1	1	1	1	11
Health sector monitoring evaluation and supervision guideline	1	1	1	1	1	1	1	0	1	1	1	10
Health program operation guideline	1	1	1	1	1	0	1	1	1	1	1	10
Waste management protocol	1	1	0	1	1	0	0	0	1	1	0	6
Municipal hospital operation and management protocol	0	1	0	1	0	1	1	0	1	0	0	5
Hospital pharmacy operation guideline	0	1	0	1	1	0	0	0	1	0	0	4
Geriatric home visit program guideline	1	0	1	0	0	0	1	0	0	0	0	3
EOC fund operation guidelines	1	0	1	0	1	0	0	0	0	0	0	3
Procedure for the health insurance program for ultra-poor citizens	0	0	0	1	1	0	0	0	0	0	0	2

CHAPTER 3

HEALTH PROGRAMS IN DAILEKH DISTRICT

National Immunization Program

The National Immunization Program (NIP), started in 2034 BS, is a priority initiative of the Government of Nepal. It has contributed significantly to reducing morbidity, mortality, and disability from vaccine-preventable diseases. NIP works with Province Health Service Directorates and District Health Offices to ensure successful immunization at local levels, especially for marginalized and hard-to-reach populations.

Connection to sustainable development goals (SDGs)

SDG 3.8 Immunization as part of Universal Health Coverage (UHC) helps prevent disease outbreaks and reduces healthcare costs.

SDG 3.2 Vaccination helps reduce child mortality by protecting against diseases like measles and polio.

SDG 3.3: Vaccines are essential in controlling communicable diseases, such as measles and polio.

Vision

Nepal: a country free of vaccine-preventable diseases.

Mission

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

Goal

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

Situational Analysis

Immunization coverage

Immunization services in Dailekh is provided from all the 90 wards from 260 EPI clinics. Over the last 3 years, the immunization coverage of the Dailekh district has significantly decreased across all the vaccines. However, the immunization coverage of the OPV vaccine has increased as compared to that of last year which was majorly contributed by the change in immunization schedule of the FIPV vaccine. Similarly, the dropout rate DPT I vs MR II is 0.8%. (Table1)

Table 11 Immunization Coverage of Dailekh District

Indicators	2078/79	2079/80	2080/81
Percentage of children under one year immunized with BCG	82.7	75.5	64.4
% of children under one year immunized with DPT-HepB-Hib1	94.1	82.9	75.8
% of children under one year immunized with DPT-HepB-Hib3	98	81.3	77.1
% of children under one year immunized with PCV 1	94	80.1	75.3
% of children under one year immunized with PCV 2	98.8	79.5	76.7
% of children under one year immunized with PCV 3	95.9	78.4	77.3
% of children under one year immunized with OPV 1	95.2	82.8	75.3
% of children under one year immunized with OPV 2	99.8	81.6	76.7
% of children under one year immunized with OPV 3	98.4	80.8	76.7
% of children under one year immunized with FIPV 1	90.5	69.1	75.5
% of children under one year immunized with FIPV 2	93.2	59.0	75.8
% of children aged 12-23 months immunized with measles/rubella 1	97.1	80.0	77.1
% of children aged 12-23 months immunized with JE	94.1	82.0	77.0
% of children aged 12-23 months immunized with measles/rubella 2	84.7	85.2	76.2

% of pregnant women who received completed dose of TD (TD2 and TD2+)	60.6	57.9	55.4
% of children fully immunized as per NIP schedule		84.9	75.4
DPT-HepB-Hib dropout rate (DPT-HepB-Hib 1 vs 3)	-4.1	2.0	-1.7
DPT-HepB-Hib1 vs MR2 dropout rate	10.7	-2.3	0.8

Among the 11 local levels in the district, only Narayan and Naumule achieved full immunization coverage exceeding 90%. In contrast, western Dailekh had the lowest coverage, with Bhairabi, Thantikandh, and Chamunda showing the fewest fully immunization coverage.

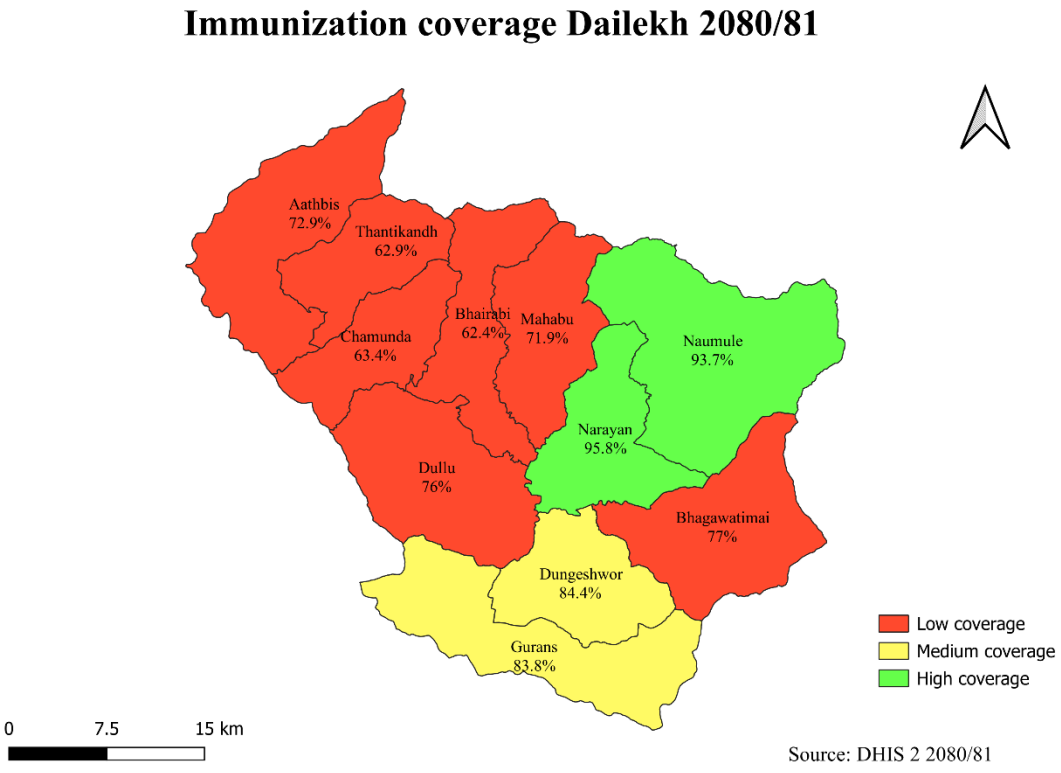


Figure 5 Immunization Coverage Dailekh

Vaccine Wastage

Nepal's "one vial per session" policy for BCG, FIPV, MR, and JE vaccines has contributed to improved vaccine coverage but has also led to higher wastage rates, particularly for BCG, where wastage exceeds the indicative rate of 50%. In Dailekh, the wastage rates for other vaccines similarly surpass the indicative values. Over the past year, the wastage rate increased by 5.5% for DPT/HepB/Hib, 1.3% for MR, and 0.9% for BCG. However, the wastage rate for other vaccines has decreased compared to the previous year.

Table 12 Vaccine Wastage

Vaccine/Period	2079/80 (%)	2080/81 (%)
BCG	91	91.9
DPT/HepB/Hib	57	62.5
FIPV	56.1	46.1
JE	67.3	65.8
MR	64.2	65.5
OPV	48.4	44.2
Rota	33.2	30
TCV	60.7	59.5
TD	60.6	55.8
PCV	91	91.9

Access and utilization of immunization services

Immunization program in local level is monitored based on the accessibility and utilization of immunization services, categorizing them into four categories. This classification is determined by DPT-HepB-Hib1 coverage and the dropout rate of DPT-HepB-Hib1 vs MR2, reflecting accessibility and utilization, respectively. In FY 2080/81, only 2 local level Narayan and Naumule exhibit both good access and good utilization, while other 9 have poor access but better utilization.

Table 13 Access and utilization of immunization services

Group	Categorization criteria	LLG name
Category 1	DPT I >= 90% Drop Out < 10%	Narayan UM and Naumule RM
Category 2	DPT I >= 90% Drop Out >= 10%	
Category 3	DPT I < 90% Drop Out < 10%	All other municipalities
Category 4	DPT I < 90% Drop Out >= 10%	

Challenges

Infrastructure and facility gap

- Lack of proper buildings for vaccination centers.
- Insufficient furniture and equipment in existing centers.
- Inadequate facilities for cold chain management.

Staffing and training issues

- Inadequate training for new health workers in vaccination programs.
- Lack of field allowance management for staff, affecting morale and motivation.
- Decline in field staff morale, motivation, and confidence.

Operational and logistical challenges

- Seasonal migration to India causes children to miss scheduled vaccinations.
- Population dynamics not correctly addressed, leading to inaccurate target populations.
- Lack of proper implementation and monitoring of immunization microplanning.
- Increased vaccine wastage rates due to mismanagement or operational inefficiencies.

Recommendations

Training and infrastructure development

- Immunization clinic construction and expansion of cold chain management should be prioritized as per necessity.
- A standardized, mandatory training should be conducted to all new vaccination workers and necessary field allowances should be provided to improve the motivation of field workers.

Operational enhancements

- Study the feasibility of conducting an “extensive search and vaccination program” during Dashain to vaccinate children who missed scheduled vaccinations due to seasonal migration to India.

- Monitor municipal level microplanning by the district and district-level microplanning by the provincial health directorate to assess program progress, providing opportunities for feedback and strategy adjustments.
- Strengthen coordination between wards and municipalities to strengthen the procurement and supply chain management of vaccines.
- Data management protocol should be strictly applied and monitored specially in the vaccine campaign time.

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

CB-IMNCI Program is an integrated package of child survival interventions and addresses major childhood killer diseases like pneumonia, diarrhea, malaria, measles and malnutrition in 2 months to 5 years children in a holistic way. CB-IMCI also includes management of infection, jaundice, hypothermia and counseling on breastfeeding for young infants less than 2 months of age. With the implementation of this package children are diagnosed early and treated appropriately for

major childhood diseases at the health facility and community level. At the community level FCHVs are the main vehicle of service delivery and also plays key role to increase community participation.

Target Population

All the children under 5 years of age

Vision

Contribute to survival, healthy growth and development of under five years children of Nepal.

Goal

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

Targets of NENAP

- Reduction of Neonatal mortality rate (per 1000 live births) to 11 by 2035
- Reduction of stillbirths (per 1000 live births) to 13 by 2035

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

Situation Analysis

In 2080/81, the incidence rate of diarrhea among children under five was 182.4 per thousand, showing a slight decline from the previous year. Additionally, 98.6% of diarrhea cases were treated with Zinc and ORS, an improvement over last year's figure. One in three children experienced ARI last year, and the pneumonia incidence rate has also decreased over time. However, the treatment rate for pneumonia cases with Amoxicillin has declined compared to the previous year.

Table 14 IMNCI indicators

Indicators	2078/79	2079/80	2080/81
Diarrhea incidence rate among U5 children (per 1000)	193.3	194	182.4
% of U5 children with diarrhea suffering from dehydration	15.2	14	12.8
% of children under five years with diarrhea treated with zinc and ORS	93.3	94.1	98.6
ARI incidence rate among U5 children (per 1000)	375.2	321.7	333.3
Incidence of pneumonia among U5 children (per 1000)	57.6	48.7	44.4
% of children U5 years with Pneumonia treated with Amoxicillin	96.5	98.1	96.4
% of infants aged 0-2 months with Possible Severe Bacterial Infection (PSBI)	21.2	14.4	8.4
% of infants aged 0-2 months with PSBI receiving a complete dose of Gentamycin	71.1	68.4	55.3
% of infants aged 0-2 months with Local Bacterial Infection	30.2	40.8	33.9

Diarrhea and pneumonia incidence rate and treatment

Diarrhea incidence rates (per 1000 children) range from lowest 88.3 in Bhairabi RM to the highest 310.9 in Narayan Municipality. Pneumonia incidence (per 1000 children) also varies significantly, from 6.5 in Bhairabi RM to 76.1 in Thantikandh RM, with nearly all cases treated with Amoxicillin, except in Narayan Municipality, where the rate is lower (65.9%). The reduced treatment rate with Amoxicillin in Narayan is due to many pneumonia cases being referred from private clinics/health post to the hospital. The treatment with amoxicillin for the referred cases may be ineffective making the treatment rate by amoxicillin lower. The notably higher disease incidence in Narayan can also be attributed to the hospital's case burden. Additionally, the incidence rates are influenced by the target population size. Delays in the procurement and supply of medicines, particularly zinc, have also contributed to lower treatment rates in some areas.

Table 15 Diarrhea and Pneumonia among U5 children

Local level	Diarrhea incidence rate among U5 (per 1000)	% of U5 diarrhea cases treated with Zn and ORS	Pneumonia incidence rate among U5 (per 1000)	% of U5 pneumonia cases treated with Amoxicillin
Naumule RM	263.2	100	20.8	100
Mahabu RM	145.9	98.5	30.8	100
Bhairabi RM	88.3	100	6.5	100
Thantikandh RM	234.5	99.7	76.1	100
Aathbis Mun	162.2	96.9	50.3	98.3
Chamunda Bi. Mun	143.1	100	19.8	100
Dullu Mun	155	98.1	66.9	100
Narayan Mun	310.9	100	58.7	65.9
Bhagawatimai RM	230.9	91.4	20.2	97.2
Dungeswor RM	159	100	61	100
Gurans RM	167.9	100	58.1	100

Temporal variability of diarrhea and pneumonia cases

The highest number of diarrhea cases among children under five was reported in Baisakh, while the lowest occurred in Kartik. Pneumonia cases peaked in Ashwin. Overall, diarrhea cases show significant fluctuations, whereas pneumonia cases remain relatively stable with minor variations.

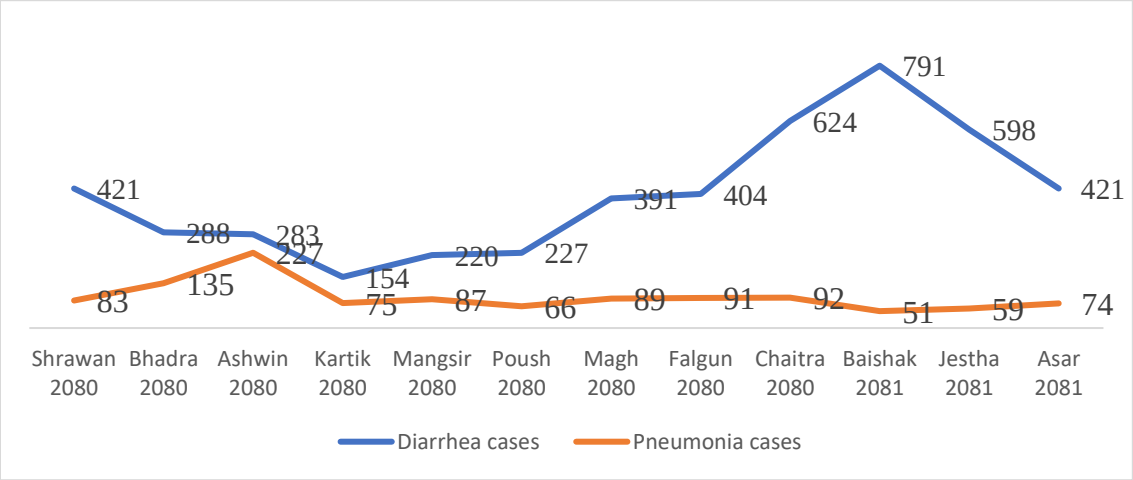


Figure 6 Temporal variability of diarrhea and pneumonia cases

Challenges

- Training deficiencies:
  - Lack of training for new health workers.
  - Lack training for new FCHVs (Female Community Health Volunteers) and refresher training for the old ones.
- Medicine management: Problems with the supply and distribution of essential medicines like Zinc.
- Lack of on-site coaching materials: Insufficient materials to conduct Community-Based IMNCI (CB-IMNCI) coaching.
- Recording and reporting issues
- Shortage of trained health workers in community health units.
- Absence of Neonatal Corners: Lack of designated neonatal corners in health facilities.

Recommendations

- Establish Stock Coordination: Coordinate with the district store and ensure timely forecasting and procurement to maintain a 12-month stock of essential materials.
- Implement "on-site coaching": conduct institutional "on-site coaching" facilitated by the health service office and municipal health section to address training and reporting issues.

- Health service office and municipal health section should monitor the treatment protocol followed by the private clinics. The treatment protocol followed by the private clinic needs to be audited.

Nutrition Program

The National Nutrition Program under Department of Health Services has laid the vision as "all Nepali people living with adequate nutrition, food safety and food security for adequate physical, mental and social growth and equitable human capital development and survival" with the mission to improve the overall nutritional status of children, women of child bearing age, pregnant women, and all ages through the control of general malnutrition and the prevention and control of micronutrient deficiency disorders having a broader inter and intra-sectoral collaboration, partnership among different stakeholders and high level of awareness and cooperation of population in general.

Children (0-23 months) who are registered for growth monitoring and promotion are monitored for both anthropometric as well as developmental milestones and general health. The program is guided by "Growth Monitoring and Promotion Guideline 2079"

Key components of nutrition strategy 2077

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

Mission: To build a nutrition friendly society

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

Strategies: Multi-sectorial nutrition policy and programs including food security will be updated and implemented with high priority.

Short-term, medium-term, and long-term measures will be adopted at all levels with an emphasis on food diversification and balanced diet to improve the micro-nutrition status of different age groups including women and children.

Programs will be developed and operated by strengthening school health programs and nutrition education. Domestic production will be promoted by encouraging the consumption of various nutritious and healthy foods

Situational Analysis

The average number of visits for growth monitoring among children aged 0–23 months increased from 8.6 to 10.6. Of those monitored, 2.9% were underweight. Bal-vita consumption has significantly declined, with only 4.5% of children receiving the recommended 180 sachets. Among those registered for growth monitoring, 76.5% were exclusively breastfed. Less than half (42.7%) of adolescent girls aged 10–19 received IFA supplements for 13 weeks.

In addition, 16.4% of children received 180 calcium sachets. Mahabu, Dungeswor, and Narayan municipalities have been distributing calcium to pregnant women through local procurement. Meanwhile, 99.4% of postpartum women received Vitamin A supplementation, with Bhairabi having the lowest rate at 89.2%.

Table 16 Major Indicators of Nutrition Program

Indicators/Period	2078/79	2079/80	2080/81
Average number of visits among children aged 0-23 months registered for growth monitoring		8.6	10.6
% of children aged 0-23 months registered and visited for growth monitoring who were underweight	4.4	3.2	2.9
% of children below 6 months exclusively breastfed among registered for growth monitoring	71.1	79.6	76.5
% of children aged 6-23 months who received at least one cycle (60 Sachets) Baal Vita	35.1	51.7	33
% of children aged 6-23 months who received 3 cycle (180 Sachets) Baal Vita in last 18 months	6.9	11.9	4.5
% of adolescent girls aged 10-19 years who received IFA supplement for 13 weeks			42.7

% of children aged 12-59 months who received anthelminthic in last six months	92.6	92.5	95.4
Number of students in grade 1-12 who received anthelminthic	5167	21270	20197
% of children aged 0-59 months who received Vitamin A in last six months	96.0	102	100
% of women who received a 180-day supply of Iron Folic Acid during pregnancy	68.9	65.9	51.2
% of women who received 180 calcium tablets during pregnancy	0	25.3	16.4
% of postpartum mother who received vitamin A supplement		99.7	99.4

In 2080/81, 127 SAM cases (children aged 6-59 months) were admitted to outpatient therapeutic centers (OTCs), 23 fewer than the previous year. One in seven children (13.7%) admitted to the OTCs defaulted, largely due to frequent parental migration to India, low literacy, and lack of awareness. Additionally, 53 MAM cases were admitted, with a recovery rate of 87.2%.

At Dailekh Hospital's Nutrition Rehabilitation Home, 60 SAM and 3 MAM cases were admitted, with 85.7% recovering and no nutrition-related deaths reported. A few defaulters were noted, particularly during festive months when families returned home.

Table 17 Major Indicators of OTC and NRH

Indicators/Period	**2079/80**	**2080/81**
Number of SAM cases (6-59 months) admitted at outpatient therapeutic centers (OTC)	150	127
% of SAM cases (6-59 months) recovered	65	74
% of SAM cases (6-59 months) admitted at OTCs who defaulted	29.5	13.7
Number of MAM cases (6-59 months) admitted at outpatient therapeutic centers (OTCs)	221	53
% of MAM cases (6-59 months) recovered	75	87.2
% of MAM cases (6-59 months) admitted at OTCs who defaulted	21.3	4.3

Number of SAM cases (0-59 months) admitted at nutrition rehabilitation center	41	60
Number of MAM cases (0-59 months) admitted at nutrition rehabilitation center	11	3
% of MAM cases admitted at NRHs who recovered	84.8	85.7

Challenges

- Inconsistent weight monitoring: Families do not regularly bring children in for weight checks.
- Shortage of Ready-to-Use Therapeutic Food (RUTF): Inconsistent availability hampers treatment efforts.
- Inadequate infrastructure: Lack of proper buildings and designated spaces for Outpatient Therapeutic Care (OTC) and activities.
- Insufficient Equipment and Materials: Essential tools for nutrition programs are lacking.
- Low participation in meetings: Caregivers often do not attend mothers' group meetings.
- Follow-up irregularity: Malnourished children frequently do not return for necessary follow-ups at OTC centers.
- Geographical Barriers: Difficult terrain increases dropout rates among malnourished children.
- Poor recording: Health facility lack proper recordings in growth monitoring register.

Recommendations

- Monitoring Reports: Establish a system for evaluating reports and providing feedback to improve accountability.
- Implement School Nutrition Programs: Develop and roll out special package programs focused on nutrition education in schools.
- Appoint Multi-Sectoral Nutrition Coordinators: Municipalities should assign dedicated personnel to oversee nutrition initiatives through the Provincial Health Directorate.
- Train Health Teachers: Equip school health teachers with training to effectively engage students and families in nutrition programs.

- Expand OTC Services: Increase availability and accessibility of OTC services at health institutions at the ward level.
- Motivate Regular Weight Monitoring Participation: Create incentives or recognition programs for families who consistently bring children for weight monitoring.

Health Promotion and Health Education Program

Health promotion and health education activities are done in school, community and other areas. In comparison to last year a significant increment in number and session is observed in total participant is seen. A total of 191 sessions were conducted in the health facility which is almost five times more than the last year progress.

Table 18 Health Promotion and Health Education Program

Indicator/Period	2079-80			2080-81		
	School	Community	Other	School	Community	Other
Number of sessions	40	129	47	191	199	44
Total participants	1887	2433	604	7314	3581	445

Female Community Health Workers Program

The major role of the FCHVs is to promote health and healthy behavior of mothers and community people for the promotion of safe motherhood, child health, family planning and other community-based health services with the support of health personnel from the HPs and PHCCs. The primary role of FCHVs is to advocate for mothers and community members, promoting healthy behaviors related to safe motherhood, child health, family planning, and other community-based health issues and services.

Goal: To improve the health of local community peoples by promoting public health.

Objectives

- Mobilize a pool of motivated volunteers to connect health programs with communities and to provide community-based health services

- Activate women to tackle common health problems by imparting relevant knowledge and skills
- Increase community participation in improving health
- Develop FCHVs as health motivators and
- Increase the demand of health care services among community people

Situational Analysis

In 2080/81, 93.4% of FCHV meetings were conducted. A total of 66,979 children underwent MUAC screening, with 2.8% identified as malnourished. Family planning service utilization through FCHVs has declined, with pill distribution reduced by half and condom distribution down by one-third compared to the previous year. Diarrhea cases treated by FCHVs have also decreased, with 98.7% treated using zinc and ORS. However, the accuracy of diarrhea treatment data is questionable due to inconsistencies in reporting across health facilities.

Table 19 Major indicators of FCHV program

Indicator/Period	2078/79	2079/80	2080/81
% of Mother groups meeting held	109.2	92.8	93.4
Number of MUAC Screening	31117	50872	66979
% of SAM/MAM cases among MUAC Screened	5.5	3.7	2.8
Pills Cycles Distribution	4883	5139	2820
No. of Condoms Pieces Distribution	101825	77433	56108
CBIMCI-(2-59) Months-Total Diarrhea Cases	16333	13621	12692
% of CBIMCI-(2-59) Months-Treated with ORS & Zinc	92.8	93.1	98.7

Challenges

- Lack of training for some newly selected Female Community Health Volunteers (FCHVs).
- Delays and inaccurate records and reports.
- No proper FCHVs program reviews.
- Limited implementation of mother group-level programs.
- Ineffective use of FCHV funds.

Recommendations

- Ensure timely selection of FCHVs and maintain accurate records and reports.
- Encourage FCHVs to timely disseminate information on community-based programs.
- FCHV meeting program should be conducted in an effective manner.
- Engage provincial and federal governments in managing budgets for semi-annual and annual volunteer review meetings.

Maternal and New Born Health

The goal of the National Safe Motherhood Program is to reduce maternal and neonatal mortalities by addressing factors related to various morbidities, death and disability caused by complications of pregnancy and childbirth. Global evidence shows that all pregnancies are at risk and complications during pregnancy, delivery and the postnatal period are difficult to predict. Experience also shows that three key delays are of critical importance to the outcomes of an obstetric emergency: (i) delay in seeking care, (ii) delay in reaching care and (iii) delay in receiving care. To reduce the risks associated with pregnancy and childbirth and address these delays, three major strategies have been adopted in Nepal:

- Promoting birth preparedness and complication readiness including awareness raising and improving the availability of funds, transport and blood supplies.
- Encouraging for institutional delivery.
- Expansion of 24-hour emergency obstetric care services (basic and comprehensive) at selected public health facilities in every district.

National Safe Motherhood and Newborn Health Roadmap 2087/88

Goal: Ensuring healthy lives and promoting wellbeing for all mothers and newborns.

Five Outcomes

- Increase the availability of high-quality maternal and new-born health services leaving no one behind.
- Increase the demand for and utilization of equitable maternal and new-born health services.
- Improve governance and ensured accountability of maternal and new-born health services.
- Improve monitoring and evaluation of maternal and new-born health services.
- Strengthen emergency preparedness of maternal and new-born health services.

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

Situational Analysis

In 2080/81, first ANC as per protocol and 4 ANC as per protocol has decreased while 8 ANC as per protocol has increased with 35% of women having 8 ANC as per protocol. Also, institutional delivery rate has also decreased by 12%. Also, number of home delivery has decreased over the years. The abortion service utilization has increased over the year, however only four-fifth (81.1%) of the women use post abortion family planning services.

Number of preterm deliveries has increased this year with increment from 45 to 59. Also, the newborn with low birth weight has increased by 0.6% in 2080/81. Total neonatal death and % of still birth children has decreased over the years.

Table 20 Major indicators of safe motherhood

Indicator/Period	2078/79	2079/80	2080/81
First ANC as per protocol (within 12 weeks)	0	61.2	55.2
Four ANC as per protocol (4,6,8 and 9 months)	71.2	73.4	55.2
Eight ANC as per protocol		26	35
Institutional delivery rate	63	74.7	62.6
Number of home delivery	173	112	83
Number of preterm delivery children		45	59
Four PNC as per protocol		46.9	44.2
Number of Safe abortion service utilization	485	645	730
% of women using post-partum family planning services	70.1	80.6	81.1
Maternal death	5	3	0

% of newborns with low birth weight (<2.5KG)	6.7	6.5	7.1
Total neonatal death	19	25	15
% of still birth	1.1	0.92	0.78
Total C/S	99	132	144

Institutional delivery and home delivery

In 2080/81, Narayan Municipality reported the highest institutional delivery rate at 129.6%, while Naumule Rural Municipality recorded the highest number of home deliveries in the district, with 32 cases. Additionally, some local levels in western Dailekh also reported instances of home deliveries.

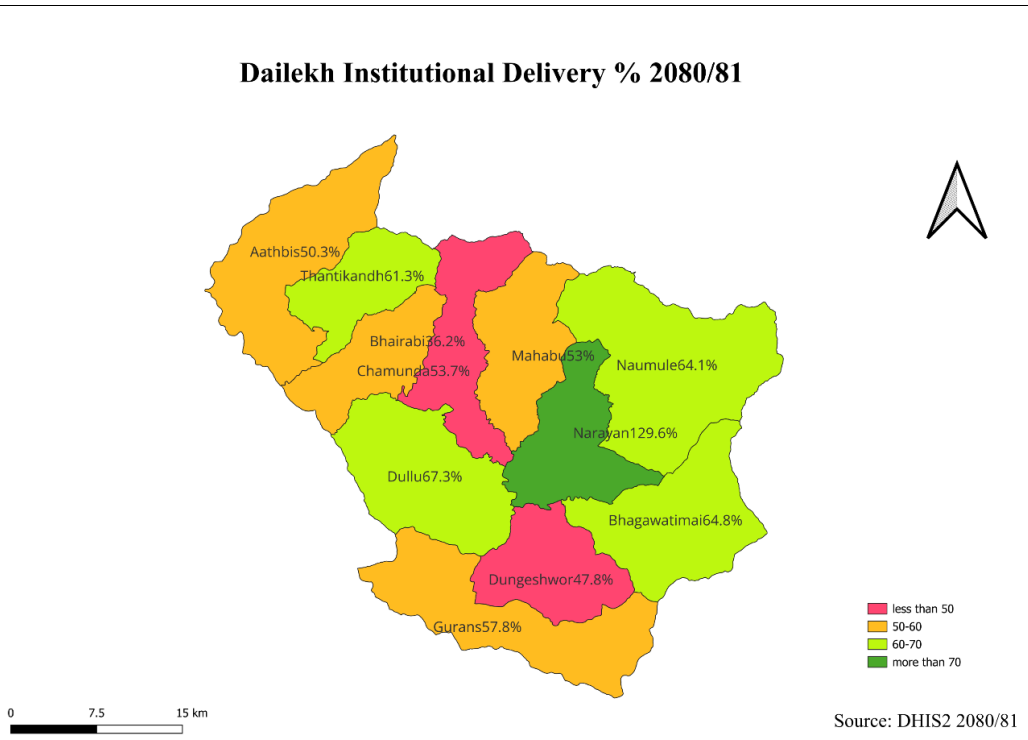


Figure 7 Institutional delivery rate

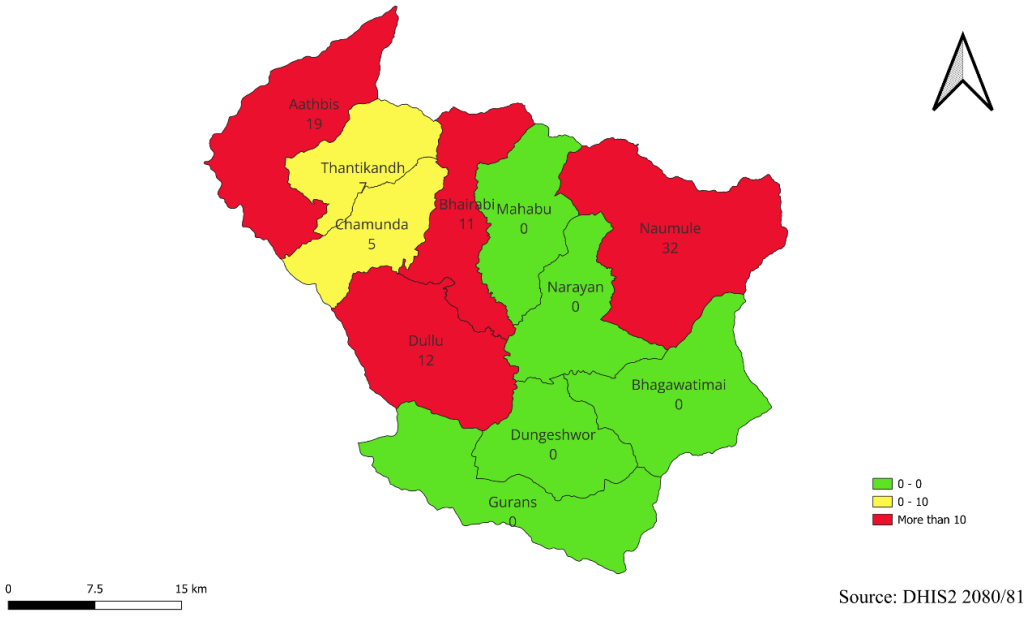


Figure 8 Number of home delivery

ANC to Institutional Delivery Continuum of care

Among the total institutional delivery, a total of 21.0% of deliveries were of under 20 mothers. The graph below illustrates that among the under 20 age group despite having first ANC as per protocol merely utilizes the 8 ANC services as compared to those with age 20 and above.

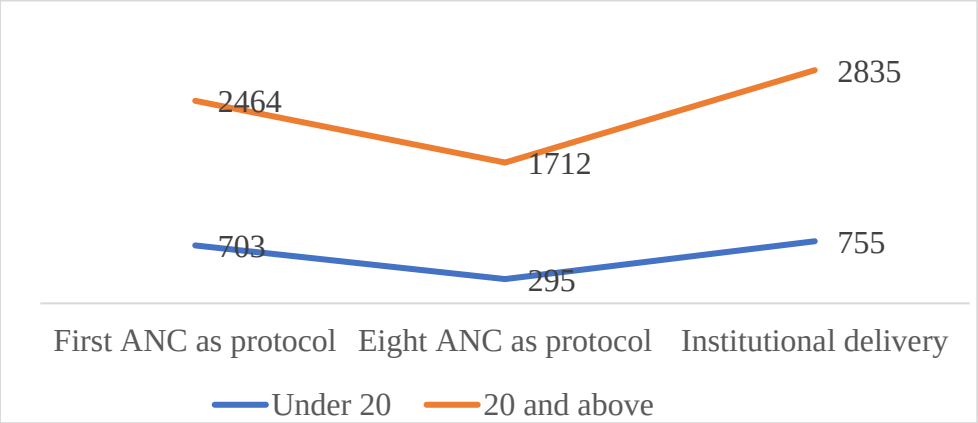


Figure 9 ANC to institutional delivery continuum of care

One in three women (37%) who attended the first ANC as per protocol missed the 8th ANC. Bhairabi saw the highest dropout rate, with half of the women missing from the first to the 8th ANC. Similarly, high dropout rates were observed in Aathbis and Bhagawatimai.

Table 21 1st ANC to 8th ANC drop out

Indicators	District/Palika	1st ANC	8 ANC	Drop out %
2080/81	Naumule RM	79.7	51	36
	Mahabu RM	50.7	32.1	36
	Bhairabi RM	35.7	18	50
	Thantikandh RM	43.4	29.2	33
	Aathbis Mun	48.5	26.5	45
	Chamunda Bi. Mun	46.4	28.9	38

	Dullu Mun	55.5	38.1	31
	Narayan Mun	85.1	53.9	37
	Bhagawatimai RM	45.3	25.5	44
	Dungeswor RM	72.7	52.6	28
	Gurans RM	66.2	47.1	29
	Dailekh	55.2	35	37

Birthing center with less than 15 deliveries

Among the 81 birthing centers in Dailekh district, 11 centers from 8 different municipalities had an annual delivery rate of fewer than 15, falling below the established threshold. Despite not being a designated birthing center, Gurans Hospital was compelled to manage referral cases, handling a total of 4 such cases last year. This raises a question, “Is establishing more birthing center a good solution in Dailekh.”

Table 22 Birthing center with less than 15 deliveries

Palika Name	Health facility	Total delivery
Narayan	Bhawani	14
	Belaspur HP	1
Dungeswor	Dungeswor BHSC	14
Naumule	CHU Kagate	13
	Paiti	13
Thantikandh	CHU Majkharkha	12
	CHU Bahakot	12
Mahabu	Badakhola HP	11
	CHU Airadi	11
Aathbis	BHSC Omkana	6
Bhagwatimai	CHU Chipin	6
	Bhagawatimai Hospital	3
Gurans	Gurans Hospital	4

Challenges

- Inadequate infrastructure and lack of essential materials, such as baby warmers and Doppler machines in some health facilities.
- Issues with availability and training of Skilled Birth Attendants (SBAs). In 81 birthing center there are around 130s SBA in Dailekh.
- Difficulty for midwives and nurses to reach homes for PNC home visit due to transportation issues.
- Insufficient water supply and solar backup in birthing center.
- Birthing centers do not meet Health Post and Maternity Services Standards (HPMSS), affecting service quality.
- Lack of housing arrangements for nursing staff working 24/7.
- Difficulty performing postnatal check-ups within 24 hours due to inadequate birthing center facilities.
- No dedicated focal person (PHN).

Recommendations

- Enforce stricter measures to prevent marriages under 20.
- Ensure availability of essential materials and medicines, and implement calcium supplementation programs.
- Expand the rural ultrasound program.
- Strengthen simulation-based onsite coaching in health posts.
- Implement programs targeting mothers' groups and enhance PNC programs through regular monitoring and supervision.
- MoSD should deploy Public Health Nurse as soon as possible
- Regular inspection of the birthing center and FCHV mother's group meeting (MGM) should be done in presence of a health worker to ensure mandatory eight prenatal check-ups for pregnant women.
- Programs focusing on improving the effectiveness of FCHV MGM and reducing the ANC drop out should be launched

- Is establishing more birthing center a good solution in Dailekh? Further study is recommended

Family Planning Program

Family planning (FP) is recognized as a fundamental right in Nepal's constitution and is included in the basic health service package under the Public Health Service Act of 2075. The National Family Planning Program focuses on expanding and sustaining quality family planning services across communities through a network of healthcare providers, including hospitals, primary health care (PHC) centers, health posts (HP), primary health care outreach clinics (PHC/ORCs), and voluntary surgical contraception (VSC) camps. The policy encourages public-private partnerships and leverages Female Community Health Volunteers (FCHVs) to promote condom distribution and resupply oral contraceptives.

Awareness campaigns on FP are enhanced through Information, Education, and Communication/Behavior Change Communication (IEC/BCC) strategies, alongside active involvement of FCHVs and Mothers' Groups, as outlined in the revised National Strategy for the FCHV program. These family planning services aim to offer a range of contraceptive options that reduce fertility, improve maternal and neonatal health, boost child survival rates, and contribute to population growth management, all of which support socio-economic development and enhance the quality of life for the Nepalese population.

Aligned with the Sustainable Development Goals (SDGs), Nepal aims to achieve a contraceptive prevalence rate of 60%, ensure that 80% of women of reproductive age (15-49 years) have their family planning needs met with modern methods, and reduce the unmet need for contraception to 10%.

Objective

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

The specific objectives are as follows:

• To increase access to and the use of quality FP services that are safe, effective, and acceptable to individuals and couples.

A special focus is on increasing access in rural and remote places with focus on marginalized people with high unmet need, postpartum and post-abortion women and partner of labor migrants and adolescents.

• To increase contraceptive use, reduce unmet need for FP, unintended pregnancies, and contraceptive 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.

Situational Analysis

In 2080/81, the contraceptive prevalence rate among women of reproductive age stood at 29.4%. A 0.6% increase was observed in new acceptors of family planning methods, largely attributed to the introduction of Sayana Press as a supplement to Depo. However, over the years there was a notable decline in the use of short-acting contraceptive methods, such as pills and condoms.

Table 23 Major indicators of family planning program

Indicator/Period	2078/79	2079/80	2080/81
Contraceptive prevalence rate	23.8	28.7	29.4
% of new acceptors of family planning methods	10.7	7.9	8.5
Current users			
Couple year of protection (CYP)	2148	1820	1370
Pills	1586	1203	1120
Depo	4401	4018	3358
Sayana Press			545
IUCD	867	857	963
Implant	3445	3681	3807

Total temporary method users	10299	9759	9793
Permanent method user	8285	8423	8556

Challenges

- Only 16 out of 107 health facilities provide all five family planning methods, primarily due to a lack of trained health workers for IMPLANT and IUCD.
- Issues with client confidentiality and limited accessibility, particularly for long-acting contraceptive devices.
- Irregular availability of family planning methods.
- Inaccurate record-keeping and reporting, especially concerning long-acting contraceptives and permanent methods.

Recommendations

- Ensure the most assessable and more health facilities are equipped with all five family planning methods.
- Strengthen family planning services through village clinics.
- Conduct annual mobile camps to provide long-term and permanent family planning services.
- Ensure timely delivery of family planning methods at the local level.

Reproductive Health Morbidities

Reproductive health right has been mentioned as a fundamental right for each woman. Reproductive health morbidity means any health condition adversely impacting the reproductive system as a result of reproduction, pregnancy, abortion, labor and sexual behavior, and also refers to pelvic organ prolapse, obstetric fistula, infertility, cervical cancer, breast cancer as well as any other similar health conditions that affects the reproductive functioning. Cervical cancer, breast cancer, obstetric fistula, pelvic organ prolapses, and infertility are among the prioritized RH morbidities.

Situational Analysis

In the fiscal year 2080/81, a total of 38 suspected cases of cervical cancer were reported, representing an almost threefold increase compared to the previous year. Additionally, one case of obstetric fistula was identified, along with three suspected cases of breast cancer. Among the 1,030 women screened for pelvic organ prolapse, 336 were diagnosed with stage 1 or 2 prolapse, 93 with stage 3, and 29 with stage 4 prolapse. Furthermore, one surgical procedure was performed.

Table 24 Major indicators of RH morbidity program

Indicator/Period		**2079-80**	**2080-81**
Cervical cancer	Screened	1230	1001
	Suspected	14	38
Breast cancer	Screened	435	556
	Suspected	3	3
Obstetric Fistula	Screened	250	273
	Suspected	0	1
Pelvic Organ Prolapse	Screened	1039	1030
	Prolapsed stage 1 &2	198	336
	Prolapsed stage 3	96	93
	Prolapsed stage 4	12	29
	Ring pessary	167	123
	Referred	125	55
	Surgery done	8	1

Challenges

- Challenges in managing suspected cases, as clients often face difficulties with referrals, particularly due to the associated transportation costs.
- Health workers tend to focus on recording only suspected cases, while normal screening results are frequently not documented, leading to an inflated positivity rate.

Recommendation

- Necessary arrangements should be made to manage suspected cases, either by providing transportation assistance or by improving accessibility to surgical procedures.
- Regular monitoring of data recording should be implemented to ensure accuracy and completeness.

Primary Health Care/Outreach clinic (PHC/ORC)

Primary Health Care Outreach Clinic (PHC/ORC) programmed was established in 1994 (BS 2051) with an aim to improve access to some basic health services including family planning and safe motherhood services for rural households. PHC/ORC clinics are extension of PHCCs, HPs at the community level. The primary responsibility for conducting the PHC outreach clinics lies with AHWs, and ANMs. At PHCC and HP level, ANMs, AHWs are responsible for conducting the PHC outreach services. HA, other health staff of HP/PHCCs also helps in conducting the PHC outreach clinics. Female Community Health Volunteers (FCHVs) and other local NGOs/CBOs support service providers in conducting PHC/ORC clinics and also for recording/reporting and other support activities.

AHWs and ANMs provide basic PHC services (FP and ANC services/Health Education/Minor treatment) to a pre-arranged place close to communities on a predetermined day once in a month. According to PHC/ORC strategy, following services are provided by PHC/ORC.

1. Family Planning
2. Safe Motherhood and New Born Care
3. Prevention and Management of Complication of Abortion
4. RTI/STI and Infertility
5. RH Intervention
6. Child Health
7. Minor Treatment
8. Communicable Disease
9. IEC/BCC Activities

Situational Analysis

A total of 95.3% of ORC clinic were conducted in 2080-81 with an average of 17.7 people being served in each clinic. The trend shows decreasing number of clients per ORC clinic. Similarly, 30,330 times children were measured in the growth monitoring.

Table 25 Major Indictors of PHC/ORC program

Indicator/Period	2078-79	2079-80	2080-81
Number of ORC clinic	215	215	208
% of planned primary healthcare outreach clinics conducted	90.7	90.3	95.3
Average number of clients served per PHC outreach clinic	19.9	18.2	17.7
Number of growth monitoring done in ORC clinic	30439	29141	30330

Challenges

- Service utilization from PHC/ORC is decreasing, as many mothers find it difficult to come at the ORC clinic for growth monitoring
- Lack of allowance to the field staffs
- Lack of proper infrastructure and logistics to run PHC/ORC.

Recommendations

- Revitalization of PHC/ORC is important. Advantages of integrating NCD monitoring and including geriatric care in PHC/ORC should be studied.
- Necessary arrangement for field allowance should be made

Epidemiology and Disease Control

Malaria Elimination Program

The high risk of getting the disease is attributing to the abundance of vector mosquitoes, mobile and vulnerable population, relative inaccessibility of the area, suitable temperature, environmental and socio-economic factors.

Objectives

The specific objectives of NMSP (2014 -2025, Revised) are as follows:

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

Situational Analysis

A total of 2,497 slides were examined in 2080-81 and 2 cases were positive which underwent treatment. The slide examination rate has increased from last year.

Table 26 Major indicators of malaria elimination program

Indicator/Period	2078-79	2079-80	2080-81
Total slide collection	371	1728	2497
Number of imported malaria cases	2	2	2
Number of indigenous malaria cases	1	0	0
Number of malaria cases that underwent treatment	3	2	2

Challenges

- Not all health workers in the 18 laboratories prepare slides for malaria examination, resulting in a lower Annual Blood Examination Rate (ABER).
- Test kits are not consistently available at health facilities.

Recommendations

- Ensure proper logistical arrangements and deploy skilled health workers in the laboratories to improve the Annual Blood Examination Rate. Additionally, maintaining a continuous supply of test kits is essential for uninterrupted malaria screening.

Kala-azar Elimination Program

Leishmaniasis is caused by an intracellular protozoan parasite, of which 20 Leishmania species can cause human disease. Leishmania parasites are transmitted through the bites of infected female phlebotomine sandflies, which feed on blood to produce eggs. Nepal aims to eliminate Kala-azar by maintaining an annual incidence rate of less than 1 case per 10,000 people at the district level, with a case fatality rate below 1%.

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

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

Objectives:

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

Situational Analysis

A total of 172 tests were done in 2080-81 but none of them were positive. Dailekh have reported no cases of leprosy in last 2 years. Last time in 2078-79, 2 cases of kala-azar were reported

Table 27 Major indicators of kala-azar elimination program

Indicator/Period	2078-79	2079-80	2080-81
Total RK-39 test collection	160	120	172
Total Kala-azar cases	2	0	0

Leprosy Elimination Program

Leprosy has existed in Nepal since immemorial and was recognized as a major public health problem. It has been a priority of the government of Nepal. Thousands of people have been affected by this disease and many of them had to live with physical deformities and disabilities.

Goal

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

Objectives

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

Situational Analysis

A total of 6 cases of leprosy were reported in 2080-81 and none of the cases had grade 2 disability.

Table 28 Major indicators of leprosy elimination program

Indicator/Period	2078-79	2079-80	2080-81
Leprosy incidence rate	0.24	0.35	0.24
Total new leprosy cases	6	9	6
Number of leprosy cases with Grade 2 disability	0	0	0

Challenges

- Low screening and enrollment in treatment of probable Leprosy cases

Recommendation

- Extensive search and screening program of probable cases of leprosy should be done to find the hidden leprosy cases.

Rehabilitation services

District hospital is the only rehabilitation services site in the district. Different types of physiotherapy services are provided in the hospital by the physiotherapy assistant.

Situational Analysis

A total of 227 clients utilized the rehabilitations service sites. Average number of sessions per client has increased over the years with from 2.1 in 2078-79 to 3.7 in 2080-81. Also, 1.9% of OPD clients utilized the rehabilitation service.

Table 29 Major indicators of rehabilitation services

Indicator/Period	2078-79	2079-80	2080-81
Number of new clients utilizing rehabilitation services	147	282	227
Total number of physiotherapy sessions conducted	316	779	837
Average number of sessions per client	2.1	2.8	3.7
Percentage of OPD clients utilizing rehabilitation service	1.4	3.5	1.9

Challenges

- Inadequate space to run physiotherapy service
- Low service accessibility to the all the people in district

Recommendation

- Outreach clinic of physiotherapy services should be conducted to improve the service utilization within the district.

National Tuberculosis Program

Tuberculosis (TB) is a communicable disease which is a major public health problem in Nepal. It is one of the top 10 causes of death worldwide and in Nepal, and the leading cause of death from a single infectious agent (ranking above HIV/AIDS). TB is caused by the bacillus Mycobacterium tuberculosis, which is spread when people who are sick with TB expel bacteria into the air; for example, by coughing. The disease typically affects the lungs (pulmonary TB) but can also affect other sites (extra pulmonary TB). About a quarter of the world's population is infected with Mycobacterium tuberculosis, which is similar for Nepal. TB can affect anyone anywhere, but most people who develop the disease are adults, there are nearly twice as more cases among men than women, and 30 high TB burden countries account for almost 90% of those who fall sick with TB each year. TB is a disease of poverty, and economic distress, vulnerability, marginalization, stigma and discrimination are often faced by people affected by TB. TB is curable with medicine (nearly 90% cure rates) and preventable. With access still falling short of universal health coverage (UHC) for all forms of TB, many still have also missed out (nearly 58% in Nepal) on diagnosis and care.

Vision: Nepal free of tuberculosis.

Long term goal: End the tuberculosis epidemic by 2050.

Short term goal: Reduce TB incidence by 20% by 2021 compared to 2015 and increase case notifications by a cumulative total of 20,000 from July 2016 to July 2021.

Objectives:

- Increase case notification through improved health facility-based diagnosis.
- Maintain the treatment success rate at 90% of patients (for all forms of TB) through to 2021.
- Provide drug resistance diagnostic services for 50% of persons with presumptive drug-resistant TB by 2018 and 100% by 2021 and successfully treat at least 75% of diagnosed drug resistant patients.
- Further expand case finding by engaging the private sector.

- Strengthen community systems for the management, advocacy, support and rights of TB patients in order to create an enabling environment to detect and manage TB cases in 60% of all districts by 2018 and 100% of districts by 2021.
- Contribute to health system strengthening through TB human resource management, capacity development, financial management, infrastructure, procurement and supply management.
- Develop a comprehensive TB surveillance, monitoring and evaluation system.
- Develop a plan to continue NTP services in the aftermath of natural disasters and public health emergencies.

SDG3 global targets:

By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.

SDG and End TB Strategy related targets:

- Detect 100% of new sputum smear-positive TB cases and cure at least 85% of these cases.
- By 2050, eliminate TB as a public health problem (threshold of <1 per million population)

Situational analysis

The incidence of TB cases increased in 2080-81 as compared to that in 2079-80. A total of 167 new cases of TB were reported in this year. Two TB cases were found to have HIV positive. A total of 96.3% of the TB cases had a treatment success.

Table 30 Major indicators of national TB program

Indicator/Period	2078-79	2079-80	2080-81
Case notification rate (all forms)	66.9	62.3	77.3
Total TB cases (New)	157	146	167
Treatment success rate	92.6	94.1	96.3
TB cases with HIV positive	3	4	2

Case notification rate and treatment success rate by local level

Thantikandh, followed by Dullu and Narayan, reported the highest case notification rates in Dailekh, with rates of 113.0 and 91.6, respectively. In contrast, Bhagawatimai, Chamunda Bindrasaini Municipality, and Mahabu recorded some of the lowest case notification rates. Furthermore, all local levels, except for Dullu, Thantikandh, and Narayan, achieved a 100% treatment success rate.

Table 31 Case notification rate and treatment success rate by local level

Local level name	Case Notification rate (all forms)	Treatment Success rate
Naumule RM	80.4	100
Mahabu RM	57.6	100
Bhairabi RM	88.2	100
Thantikandh RM	113	92.3
Aathbis UM	66.7	100
Cha. Bindr. UM	56.2	100
Dullu UM	91.6	87.1
Narayan UM	91.6	92.3
Bhagawatimai RM	51.5	100
Dungeshwor RM	86.3	100
Gurans RM	64.1	100

Challenges

- Insufficient screening of presumptive cases at the local level compared to established targets.
- Limited community engagement in the TB program, despite its designation as a priority (P1) program.
- High rates of defaulters due to the frequent migration of economically disadvantaged TB patients to India in search of better opportunities for daily survival.
- Decreased funding for the TB program.

- Delays in the timely recruitment of a TB coordinator at the local level for the TB-free program implementation.

Recommendations

- Implementing TB literacy programs for local leaders, students, and Female Community Health Volunteers (FCHVs), along with establishing a referral mechanism, is essential to enhance community involvement and facilitate the referral of presumptive TB cases to health facilities.
- Timely tracking and diagnosis of presumptive cases must be prioritized.
- Engaging local leaders is crucial for managing cases involving individuals with low economic conditions.

HIV and STIs Control and Management Program

History of Nepal's response against HIV/AIDS began with the launching of first National Prevention and Control Program in 1988. Nepal started its policy response to the epidemic of HIV through its first national policy on acquired immunity deficiency syndrome (AIDS) and Sexually Transmitted diseases (STDs) control, 1995 (2052 BS). Taking the dynamic nature of the epidemic of HIV into consideration, Nepal revisited its first national policy on 1995 and endorsed the latest version: National Policy on HIV and Sexually Transmitted Infections (STIs), 2011. A New National HIV Strategic Plan 2016-2021 has been launched to achieve global goals of 90-90-90 by 2020, 90% of all people living with HIV (PLHIV) will know their HIV status by 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy will have viral suppression.

SDG-3 target related to HIV:

Eliminate HIV, TB and malaria and other tropical diseases, and water borne diseases by 2030. Dailekh is among top districts in contribution to HIV cases of Nepal. Aathbis, Dullu municipality of Dailekh shares for more than half of all cases of the district and is a neighboring municipality to Accham district which is the district with most cases of HIV in Nepal.

Situational Analysis

There are a total of 222 HIV clients on ART as of Asar 2081. A total of 8 new cases were tested as positive in 2080-81. Furthermore, 4731 pregnant women were tested for HIV and 1003 were tested for Syphilis.

Table 32 Major indicators of HIV control program

Indicator/Period	2078-79	2079-80	2080-81
Number of HIV patients on ART	203	215	222
Total HIV tested	1174	773	383
Total new HIV positive patients	4	6	8
Number of pregnant women who tested HIV	4583	5621	4731
New pregnant women who were tested HIV positive	0	0	0
Number of pregnant women who screened for Syphilis		130	1003
Number of pregnant women who tested positive for Syphilis		1	2
Number of Syphilis positive women receiving treatment		1	2

Local level wise distribution of HIV prevalence

The highest number of ART enrollees are from Aathbis municipality with a total of 90 cases followed by Dullu municipality.

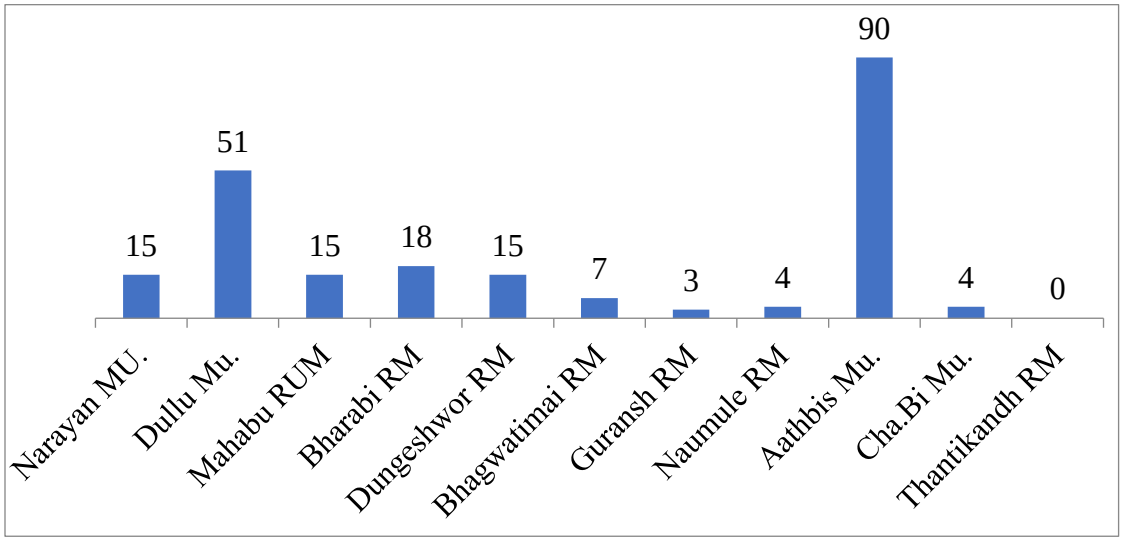


Figure 10 Local level wise distribution of HIV prevalence

Challenges

- The absence of a reporting format for referred cases, such as syphilis, has complicated the reporting of positive cases.
- Some health facilities face a shortage of test kits, while duplication of PMTCT tests occurs in hospitals for women already tested at the health facility level.
- Migrant workers are less likely to seek services due to social stigma.
- Limited access to viral load testing services.

Recommendations

- Frequent viral load testing services should be arranged.
- The HMIS reporting format should be improved to ensure referred cases are properly documented.
- The availability of PMTCT kits in health facilities must be guaranteed.

Non- Communicable Disease and Mental Health

Non-communicable diseases (NCDs) are emerging as the leading cause of death globally and also nationally due to changes in many social determinants like unhealthy lifestyles, globalization, trade and marketing, demographic and economic transitions.

Situational Analysis

As compared to 2079-80, non-communicable diseases, mental health and injury related cases has increased in 2080-81. The introduction of new dataset in 2079-80 has caused underreporting in that year. In addition, HMIS training, regular feedback, increased trained human resources for proper diagnosis and management of NCD cases increased the diagnosis which is also reflected in the table below.

Table 33 New cases of NCD

Non-Communicable Disease (New)	2079-80	2080-81
Hypertension	663	1667
COPD	748	1342
Asthma	1141	1337
Diabetes	68	320
Mental Health (New)		
Anxiety	50	382
Depression	38	195
Epilepsy	14	99
Psychosis	9	85
Alcohol Use Disorder	3	28
Injury (New)		
Bites	48	764
Fall	500	744
Occupational Injury	168	613
Burn	162	254

Challenges

- Inadequate diagnosis and enrollment for non-communicable diseases (NCDs) as compared to national prevalence.
- Many paramedics are not trained to diagnose NCDs and mental health-related conditions.
- Underreporting of NCD data, with significant discrepancies between OPD morbidity and NCD datasets.
- Lack of proper monitoring for NCD follow-up cases.

Recommendations

- NCD screening should be periodically integrated into outreach clinics to improve accessibility.

- NCD focal persons should monitor data quality and follow up cases.
- Data validation rules should be implemented in the DHIS2 NCD dataset to ensure consistency and data quality across the NCD dataset.

Curative Services

In Dailekh district, 107 public health facilities and several private clinics provide curative health services. The Dailekh District Hospital serves as the district's primary referral site, supported by Dullu Hospital, four basic hospitals, two primary health care centers (PHCCs), and other health facilities. While Dailekh District Hospital consistently offers consultant services, Dullu Hospital faces challenges in maintaining continuity of these services.

Situational Analysis

Top 10 Disease

Lower respiratory tract infection was the most frequent disease in 2080-81 with a total of 21,572 cases in district. However, the incidence rate has decreased over the years. Similarly, an increment in cases of hypertension and conjunctivitis was seen in last year with a rise of hypertension cases from 3166 in 2079-80 to 5316 in 2080-81.

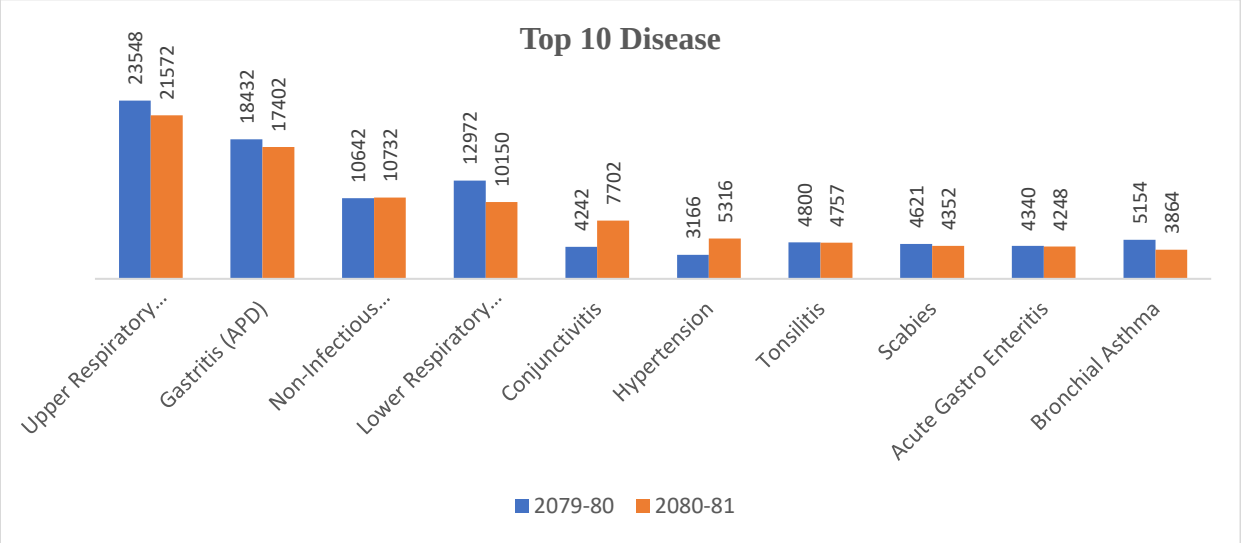


Figure 11 Top 10 Diseases

Number of OPD visit per 1000

The OPD service utilization was seen highest in the Narayan municipality with a total of 1472.1 clients per 1000. The high visit is majorly contributed by the hospital data where more than 10,000 new OPD cases visit. Similarly, the lowest OPD service utilization was seen in Bhairabi and Chamunda municipality.

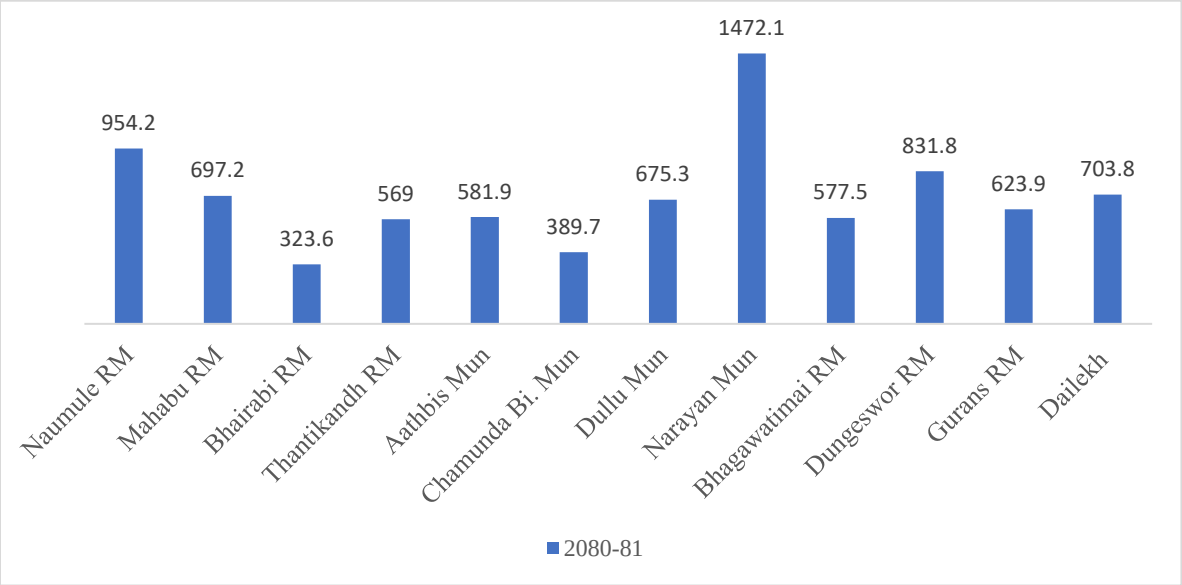


Figure 12 Number of OPD visit per 1000

Challenges

- Diagnosis Discrepancy: Health workers often diagnose the same cases differently, for example, one diagnosing Acute Gastroenteritis (AGE) while another labels it as non-infectious diarrhea. This inconsistency affects the reported disease patterns across regions.
- Limited Resources: Many health facilities lack the necessary equipment and trained personnel to accurately diagnose a wide range of diseases.

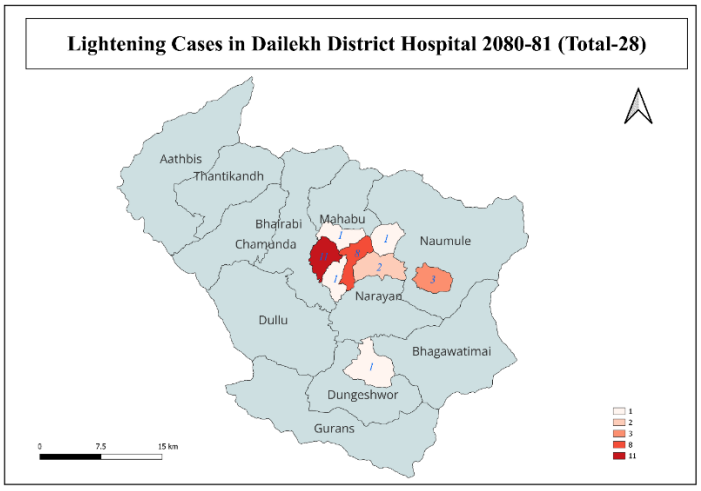
- Inadequate EHR and DHIS Integration: Diagnostic data in Electronic Health Records (EHR) is limited, and there is poor integration between EHR systems and the District Health Information System (DHIS).

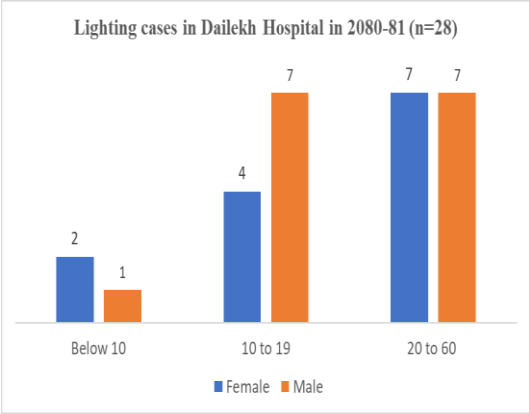
Recommendations

- Implement measures to track and ensure uniformity in diagnoses, including appropriate standardization and guidelines for health workers.
- Strengthen the interoperability between EHR and DHIS2 to ensure seamless data transfer and comprehensive disease reporting.
- Equip health facilities with the necessary tools and training for accurate and consistent diagnosis.

Lightening cases in Dailekh district hospital

A total of 28 lightning-related cases were reported at Dailekh District Hospital. Of these, 21 (three-fourths) were from Mahabu Rural Municipality, with 3 cases each from Narayan and Naumule, and 1 from Dungeswor. The map below highlights the increased lightning risk in the northeastern part of Dailekh. Lightning has affected people across all demographics, with the highest incidence occurring in the months of Bhadra and Asoj, each recording 11 cases. Additionally, 1 case was reported in Shrawan 2080, followed by 2 cases in Baisakh 2081, and 3 cases in Asar 2081.





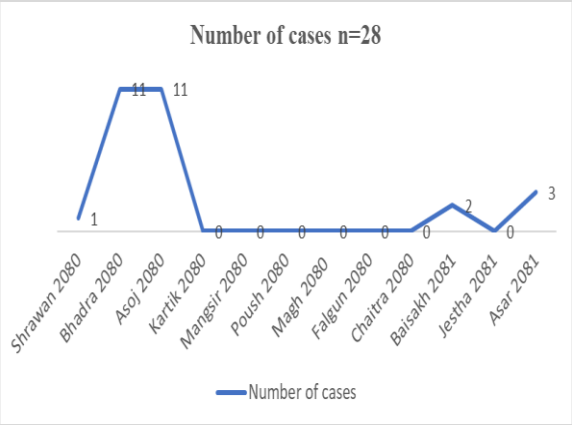


Figure 13 Lightening cases in Dailekh district hospital

CHAPTER 4

HEALTH CARE BUDGET AND EXPENDITURE

In FY 2080/81, the Health Service Office in Dailekh was allocated a total budget of Rs. 24,55,80,000. Of this, 62.95% was utilized, achieving 73.74% physical progress. The low overall budget expenditure was primarily due to delays in the construction of the new health service office building, which resulted in only 24.95% of the budget being spent during the fiscal year. Additionally, minimal spending occurred from the conditional grant provided by the EDCD, as the search and destroy program was not completed on time. Similarly, several programs funded by the conditional grant from the FWD were not completed due to the unavailability of a public health nurse at the hospital.

Table 34 Budget expenditure of health service office

SN	Program	Annual Budget	Physical Progress (%)	Annual Expenditure	
				Total Rs	%
Capital					
1	Health Service Office	102300000	41.34	25520418.0	24.95
2	Family Welfare Division (Conditional grant)	400000	100	398664.0	99.67
Total		102700000	41.57	25919082.0	25.24
Operational					
1	Health Service Office	83394000	99.12	77498637.48	92.93
2	EDCD	610000.00	59.00	349747.0	57.34
3	NHEICC	8280000	100.00	7078542.0	85.49
4	AIDS and STIs Control Program	695000	95.0	564312.8	81.20
5	Leprosy Control and Disability Prevention Program	115000	93.5	101000.0	87.83
6	Health Management Program	5640000	82.50	4507489.0	79.92

7	Health Sector Improvement Program	3635000	100	3609262.0	99.29
8	TB control program	719000	90.0	549650.0	76.45
9	Family Welfare Division	39792000	66.61	34415423.0	86.49
Total		142880000	96.86	128674063	90.06
Total Operational		142880000.0	88.08	154593145.28	108.20
Total Capital cost		102700000.0	41.57	25920418.00	25.24
Total (Capital+ Operational)		245580000.0	73.74	154594481.28	62.95

CHAPTER 5

INNOVATIVE ACTIVITIES AND MAJOR ACHIEVEMENT

Several notable and innovative health initiatives have been implemented at the health service office and across different local levels. Some of the key activities include:

- **Calcium tablet distribution:** Municipalities like Mahabu, Narayan, and Dungeswor have taken the initiative to distribute calcium tablets to pregnant women through local procurement.
- **Morning conferences:** The Health Service Office holds daily morning conferences at 10 a.m. to discuss significant events from the past 24 hours and plan the way forward.
- **Learning and sharing program:** A program for health section chiefs from all 11 local levels was conducted to share unique ideas and innovative practices.
- **Virtual data management meetings:** The Health Service Office initiated monthly virtual meetings for data management with health workers from the local levels.
- **Insurance services at Rakam hospital:** Rakam Hospital signed an agreement with the Health Insurance Board to introduce insurance services.
- **Health camps:** Various health camps, including eye camps, reproductive health morbidity camps, geriatric camps, and orthopedic camps, were conducted across the district.
- **Home visit programs:** Municipalities like Narayan, Chamunda, and Aathbis launched home visit programs for geriatric populations, differently-abled children, and pregnant women.
- **EOC fund initiatives:** Municipalities such as Dullu, Chamunda, and Bhagawatimai established Emergency Obstetric Care (EOC) funds.
- **Faith healer orientation:** Mahabu Municipality conducted an orientation program for faith healers to improve referral services.
- **Postpartum support:** Kandhikandh Health Post provides free logistics and food to postpartum mothers to encourage a 24-hour stay at the health facility.
- **Father's group meetings:** Mahabu Municipality organized meetings with fathers to promote maternal and neonatal health (MNH), increase family planning service utilization, and reduce early marriages.

- **Household surveys:** Gurans Municipality conducted a household survey, mobilizing Female Community Health Volunteers (FCHVs) to estimate the exact target population, while Tribeni Health Post completed a similar survey at no cost.
- **District hospital achievement:** District Hospital Dailekh achieved the highest Minimum Service Standards (MSS) score among hospitals in Karnali Province, with a score of 89%.
- **Hospital construction contract:** The contract for the hospital construction was extended until Bhadra 30, 2082.
- ***Asal aama protsahan* program**: Narayan Municipality introduced a program to reward mothers who received four antenatal care (ANC) visits, delivered after 20 weeks, had institutional deliveries, and ensured their children were fully immunized.
- **Healthy cooking demonstrations:** Tribeni Health Post and Dungeswor Rural Municipality provided cooking demonstrations and food services to mothers bringing their children for growth monitoring.

CHAPTER 6

DEVELOPMENT PARTNERS IN DAILEKH

Organization Name: Everest Club, Dailekh

Project Name: Strengthening Maternal and Neonatal Health Service in Partnership with the Local Government (SMNHS) Project

Thematic area: Maternal and Neonatal health

Objectives

- To strengthen the health system through capacity building.
- To increase MNH service demand
- To increase MNH service delivery
- To capacity enhancement of MNH service providers
- To improve the quality of MNH services

Working sites: 11 municipality (90 wards) of Dailekh district

Major Activities done in 2080/81
1. TOT on HFOMC at district/provincial level 2. HFOMC training at HF level 3. HFOMC monthly meeting's follow up 4. Health planning and budgeting workshop (phase 2) 5. Consultation meeting with local government 6. One-day orientation to the local government representative, HFOMC and FCHVs on CHSB. 7. Conduction of health mother's group meetings using self-applied tool for quality health 8. Interface meeting involving HFOMC members, health workers, service users, FCHVs, representatives from CBOs, local influential leaders, and representative from local government

9. Orientation and mobilization of 'student champion' on MNH focusing on the local barriers
10. Interaction program with pregnant, recently delivered women, caretakers, and family members to increase health-seeking behavior
11. Celebration of days related to maternal, neonatal, and child health at the local level
12. BPP/MISO refresher training to FCHVs and Health workers at HF
13. MNH program review with FCHV including BPP/MISO
14. MNH message broadcasting via radio/FM
15. Support to introduce and continue the teleconsultation services to PW/RDW
16. SBA training
17. RUSG Training
18. Simulation based onsite coaching mentoring training
19. Implant training
20. Onsite coaching and mentoring to MNH service providers-first time
21. Program consultative and planning meeting at district level with respective
22. Conduct a mentor development training (Nursing & Medical doctor)
23. Establishment of simulation room and SBMP program orientation
24. Conduct a pre and post assessment at Hub site
25. Conduct a monthly session at hub site
26. Conduct a monthly virtual session for spoke site including remaining BC of district
27. Support essential equipment to BC/BEONC/CEONC/referral hospital/training site - first time
28. Expansion of kangaroo mother care services (KMC) at selected Primary Health Care
29. Follow up KMC and PPFP services
30. First time MSS/QIP for health facilities
31. MSS/QIP for health facilities follow up
32. Tracking of maternal deaths, validation and reporting to concerned health facilities and Palika
33. Review of maternal deaths along with local stakeholders
34. Support to conduct annual review and planning meeting at Palika level

35. Support to conduct annual review and planning meeting at district level (involving all local level)
36. Joint supportive supervision and monitoring visits with representatives from local municipalities,
37. Integrated monitoring/meetings with health facilities/Districts/Province
38. OHW plan/progress sharing to municipality
39. OHW plan/progress sharing with HSO/DCC

Major Achievements

In the fiscal year 2080/81, significant progress was made in strengthening maternal and neonatal health across various palikas and wards. Key achievements include:

- **Improved Institutional Deliveries:** HFOMC training, committee members better understood their roles, leading to effective fund allocation and a substantial reduction in home deliveries. This contributed to an increase in institutional deliveries.
- **Advocacy and Service Enhancement:** We successfully advocated for better service utilization, ensuring the distribution of *Nyaano Jholas* in areas where they were previously unavailable. This has contributed to improved maternal care practices.
- **Community Knowledge Enhance:** Birth Preparedness Package (BPP) sessions enhanced the knowledge of FCHVs and the wider community, promoting safe maternal health practices.
- **Prevention of Postpartum Hemorrhage:** A total of 25 mothers who delivered at home were provided with misoprostol, effectively preventing postpartum hemorrhage and improving maternal health outcomes.
- **Capacity Building of Health Staff:** The Simulation-Based Mentorship Program enhanced the knowledge, skills, and capacity of nursing staff, which directly improved the readiness and quality of services at birthing centers.

- **Readiness, Availability and quality:** Through the MSS program, the readiness of various health facilities has significantly improved. The support from HFOMCs in ensuring the availability of essential equipment has been commendable, contributing to the enhanced quality of health services provided. These achievements reflect the comprehensive efforts undertaken to improve maternal and neonatal health outcomes in the region.
- **Capacity Enhancement:** Long-term training programs such as SBA, RoUSG, and Implant training have enhanced service utilization, improved the quality-of-service delivery, and strengthened the capacity and confidence of health workers.
- **Smooth Operation:** From HPBW program budget allocation in safe motherhood has improved along with the smooth operation of Health facilities.

Essential Equipment support for Skill Lab in Simulation Based Mentorship Program:

S.N.	Name of Palika	Name of Health facilities	Total Budget
1	Narayan UM	District Hospital	73,344.88
2	Dullu UM	Dullu Hospital	315,494.84
3	Naumule RM	Naumule PHC	315,494.84
4	Thantikandh RM	Lakandra PHC	315,494.84
5	Mahabu RM	Bansi HP	315,494.84
Total			13,35,324.24

Essential Equipment support for Birthing Centers:

S.N.	Name of Palika	Name of Health Facilities	Total Budget
1	Naumule RM	Naumule PHC	1,42,295.25
2	Naumule RM	Dwaari HP	1,86,913
3	Naumule RM	Baluwatar HP	2,13,942.90
4	Aathbis UM	Sigaudi HP	1,25,554.30
5	Thantikandh RM	Tolijaisi HP	1,85,173.10
6	Thantikandh RM	Lakandra PHC	1,49,193.90
7	Dungeshwor RM	Dandaparajul HP	1,18,457.90
8	Dungeshwor RM	Belpata HP	2,12,812.90

9	Gurans RM	Goganpani HP	1,91,924.85
10	Dullu UM	Badalamji HP	2,25,463.25
11	Dullu UM	Malika HP	1,38,046.45
12	Mahabu RM	Bansi RM	2,22,524.40
Total			21,12,302.5

Total budget and Expenditure
1,27,51,780.7

Organization Name: People's Participation for Sustainable Development Nepal (PASS-Nepal)

PASS-Nepal is based in Salyan and is engaged in implementing programs related to Sexual and Reproductive Health and Rights (SRHR) with the support and partnership of Ipas NEPAL.

Project Name: Strengthening Sustainable Sexual Reproductive Health and Rights (SRHR) program in Nepal

Thematic area: SRHR, Governance, Climate Change and Disaster Risk Reduction, Social Behavior Change Communication

Objectives

- Enhance the agency building of women and girls through the self-mobilization of Samudayik Aguwa (Natural Leaders), and youth and adolescents in collaboration with empowered Civil Society Organizations (CSOs), to challenge and transform social norms while holding duty bearers at all levels of government accountable for ensuring equitable access to SRHR services.
- Strengthen the health system pathways and capacity to ensure improved access, availability, quality, and acceptability of responsive and sustainable Sexual and Reproductive Health and Rights (SRHR) services, even in humanitarian settings.

Improved policies, laws, and financing mechanisms at all levels of government to support the delivery of responsive and sustainable SRHR services, including in humanitarian settings, thereby strengthening the overall healthcare system.

Working sites: Aathabis Municipality and Dullu Municipality, Dailekh

Major Activities done in 2080/81
• Selection and training of natural leaders on SRHR. • Community SRHR sessions and campaigns in unreached areas. • Capacity building and mobilization of youth for SRHR at schools and communities. • Conduct CHSB dialogues to improve accountability and SRHR access for marginalized women. • FCHV orientation on SRHR and safe abortion services (SAS). • Radio broadcasts to raise SRHR and SAS awareness. • LPAC meeting facilitation. • SNCIDRA assessments for informed decision-making. • Sensitization of elected women on abortion and related SRHR issues. • Policy dialogue with local governments on budget and mentorship for SRHR. • Strengthen HFOMCs for effective SAS implementation. • MA training for comprehensive abortion care. • Development and support for LAPA, disaster preparedness, and response. • Formation and training of Disaster Rapid Response Teams.plan/progress sharing with HSO/DCC
Major Achievements
• 11 community women trained on SRHR, GBV, and climate change; 88 SBCC sessions conducted • 4 adolescents and youth trained on SRHR and 4 health workers trained and listed for MA services • 4 personnel trained for the Disaster Rapid Response Team. • Dullu municipality. LAPA developed; reproductive health camp held in Binayak ward 13.

• Community Health Score Board implemented at Rakam Karnali Basic Hospital to improve SRHR access for marginalized women and girls • 4 HFOMC meetings held to strengthen safe abortion services. • 41 FCHVs oriented on SRHR, safe abortion, and climate change. • 2 social norms and climate-induced disaster response assessments prepared. • 27 health facilities assessed and service listings updated.
Total budget and Expenditure
Rs 2415130.25

Organization name: Kapilvastu Integrated Development Services-KIDS

Project Name: Global Fund-Tuberculosis Program

Thematic area: Tuberculosis

Objectives

- To build, strengthen, and sustain health system and create an enabling environment for ending TB by 2025/26.
- To scale up TB detection, treatment, and preventative services by 2025/26.

Working sites: 48 DOTS center of all the 11 local level

	Description
Major Activities done in 2080/81	SR's interventions in Dailekh: 1. Sputum Collection & Transportation. 2. Contact Tracing of DS & DR TB. 3. Drug Sensitivity test for possible drug-resistant TB. 4. Health Facilities and Hospital based diagnosis of childhood TB. 5. Tuberculosis Preventive Therapy.

	6. Active Case Finding (ACF) 7. Annual Review of TB Program at Local Level.
Major Achievements	**<u>Sputum Collection & Transportation:</u>** In the last fiscal year (2080/81), total 1571 sputum were transported for the sputum collection & transportation activity out of which 73 were detected tuberculosis with the positive rate of 4.64%. Where below mentioned types of TB cases were diagnosed • **PBC:67** • **PCD: 4** • **EP: 2** Around two third sample were tested by the means of Gene Xpert at district hospital, Dailekh i.e. 1028 and for remanning sample, sputum microscopy test was done at designated microscopy centers**.** **<u>Contact Tracing of DS & DR TB:</u>** • Number of households of index PBC and Child TB cases visited:101 • Number of family members screened for TB:310 • Number of family members identified as presumptive TB:138 • None case was diagnosed from contact tracing in the F/Y 2080/81. **<u>Health Facilities and Hospital based diagnosis of childhood TB:</u>** • Number of presumptive child TB cases referred to district hospital for diagnosis:14 • Number of child TB cases diagnosed:2 • Number of Child TB cases enrolled in treatment: 2 • Number of children identified as presumptive TB in district hospital: 116 **<u>Tuberculosis Preventive Therapy:</u>**

	• No. of children (less than 5 years of age) identified in household contact tracing of index TB cases:22 • Number of children (less than5 years of age) eligible for TBPT:18 • No. of children (less than5 years of age) enrolled under TBPT:18 • No. of children completed TBPT course: 13 **<u>Active Case Finding (ACF):</u>** • ACF was done at Bhairabi RM where 58 presumptive were identified out of which 2 new TB case were diagnosed and enrolled on treatment.
Expenditure only for interventions	NPR. 862697.72

ANNEX

I. Contact details of Health Section Chiefs

SN	Local level name	Name/Surname	Mobile number	Gmail
1	Narayan UM	Lal Bahadur Khadka	9858050754	narayanmun@gmail.com
2	Dullu UM	Bishnu Bahadur Shahi	9858050237	vishnushahi97@gmail.com
3	Aathbis UM	Devraj Timilsena	9840577171	drtimilsena246@gmail.com
4	Chamunda Bi. UM	Man Kumari Shahi	9851190882	shahimankumari1@gmail.com
5	Thantikandh RM	Rabindra Bhandari	9868160099	bcrabin0099@gmail.com
6	Naumule RM	Bhupendra Shahi	9868122945	naumulehealthsection2074@gmail.com
7	Bhairabi RM	Shamser Bahadur Bista	9858072230	bistaser@gmail.com
8	Mahabu RM	Ramesh Kumar Dasaudi	9858050466	dasaudirameshkumar@gmail.com
9	Bhagawatimai RM	Tikaram Bista	9844808019	trbista4@gmail.com
10	Dungeswor RM	Laxman Khatri	9848001589	laxmankhatri@gmail.com
11	Gurans RM	Narayan BC	9864936213	

II. Contact Details of Sections of HSO, Dailekh

S.N.	Section of HSO Dailekh	Phone Number
1	Emergency Section	089-410185
2	Indoor Section	9868027282
3	Health Service Manager	089-410117, 9858023564
4	Information Officer	9858080157
5	Administration	089-410127
6	Store	089-410157
7	Accounts	089-410115
8	Nutrition Rehabilitation Home	089-410198
9	Hospital Canteen	089-410223
10	Pharmacy Section	9858081157

III. Description of HSO, Dailekh Employee

S.N.	Name/Surname	Designation	Phone Number
1	Dr. Ratna Bir Sunar	Act. Health Service Manager	9858023564
2	Dr. Rahish Koju	Consultant MDGP	9843803704
3	Dr. Sabina Dahal	Medical Officer	9860922273
4	Dr. Abhishek Jha	Medical Officer	9804496706
5	Dr. Manoj Bishowkarma	Medical Officer	9860246267
6	Dr. Bikash Mahatara	Medical Officer	9843932186
7	Dr. Jitendra Tamanag	Medical Officer	9860246227
8	Dr. Sudip Khadka	Medical Officer	9867133226
9	Dr. Jagadish Chandra Mahat	Medical Officer	9844388880
10	Dr Nawal Kishor Yadav	Medical Officer	9745726710
11	Dr. Sabhyata Paudel	Dental Surgeon	9867159510
12	Dr. Arjun Rawat	Dental Surgeon	9843746989
13	Thir Prasad Regmi	Immunization Officer	9858045127
14	Deepa Upadhayaya	Public Health Officer	9869009663
15	Yagya Raj Shahi	Medical Lab technologist	9866236737
16	Kishan Singh Bisht	Hospital Management Officer	9848897569
17	Nandalal Jaishi	Public Health Inspector	9858080157
18	Motiram Rokaya	Statistics Officer	9848038938
19	Nawaraj Subedi	Public Health Inspector	9844871354
20	Naina Gurung	Hospital Nursing Inspector	9848063625
21	Nabin Kumar Dhakal	TB leprosy Inspector	9868032558
22	Tak Bahadur Bhandari	Lab Assistant Inspector	9848049945
23	Puskar BC	Administrative Officer	9858366262
24	Dipak Nepali	Account Officer	9855044855
25	Pratima Gauli	Hospital nursing Inspector	9868122313

S.N.	Name/Surname	Designation	Phone Number
26	Beena Chaudhary	Hospital Nursing Inspector	9849428060
27	Kalpana Basnet	Staff Nurse	9868933681
28	Puspa Budha	Staff Nurse	9863653358
29	Hema Upadhayaya	Physiotherapist	9841337267
30	Samjhana Sharma	Staff Nurse	9866169909
31	Dipak Karki	Radiographer Inspector	9848048202
32	Naresh Lamsal	Sr. Dark Room Assistant	9848207812
33	Anisha Kumari Yadav	Health Assistant	9807699916
34	Prakash Adhikari	Medical Recorder Supervisor	9843411152
35	Dipendra Shah	Anesthesia Assistant	9840986666
36	Kamala Bhattarai	Sr. ANM	9848007882
37	Dhan Maya Gurung	Lab Assistant	9822413557
38	Lokraj Pant	Pharmacy Supervisor	9848682262
39	Sweta Kumari Chaudahry	ANM	9846576517
40	Sunita Chaudhary	ANM	9866931718
41	Tulsara Regmi	ANM	9746533378
42	Bal Kumari Khadka	Cold Chain Supervisor	9848078563
43	Avinash Kumar Shah	AHW	9811227831
44	Sunita Khatri	Staff Nurse	9825509462
45	Parbati Regmi	Staff Nurse	9844494446
46	Ranjita Giri Khadka	Lab Technician	9841663684
47	Dipen Koirala	Pharmacy Assistant	9869689518
48	Dil Kumari Adhikari	Pharmacy Assistant	9825593069
49	Anita Oli	ANM	9844741505
50	Nagendra Rawal	Lab Assistant	9868032572
51	Gita Kumari Khadka	ANM	9864942306

S.N.	Name/Surname	Designation	Phone Number
52	Bharat Sijapati	ANM	9848100015
53	Laxmi Giri	ANM	9866229236
54	Pramila Khadka Chhetri	ANM	9812408770
55	Radha Khatri	ANM	9868910570
56	Suman Ghale	ANM	9804579563
57	Bimal Kumar Budha	AHW	9868058860
58	Dwarika Thapa	AHW	9848058871
59	Indra Rawal	AHW	9848277728
60	Puspa Kumari Bhandari	AHW	9848090430
61	Asmita KC	AHW	9868027206
62	Kumar Khatri	AHW	9867421500
63	Tej Bahadur Bam	AHW	
64	Dil Kumari Basnet	AHW	9825593069
65	Shambhu Kumar Thapa	Lab Assistant	9868004084
66	Ram Bahadur Baduwal	AHW	9868005223
67	Prakash Shahi	Computer Operator	9848078609
68	Durgaram Sunar	ART Counsellor	9849505528
69	Man Kumari Shahi	Computer Operator	9848211602
70	Shraddha Parajauli	KIOCH Program Officer	9860514035
71	Aashish Shrestha	KIDS District Co-Ordinator	9848792208
72	Prem Nepali	Volunteer	9848399537
73	Sushila Kumari Bhandari	Volunteer	9484141738
74	Manakamana Chand	Volunteer	
75	Upendra KC	Bio Medical technologist	9848167901
76	Purna Bahadur Basnet	Driver	9860892314
77	Arjun Kumar Shahi	Driver	9868165682

S.N.	Name/Surname	Designation	Phone Number
77	Min Bahadur Shrestha	Helper	9848059094
78	Dil Bahadur Thapa	Helper	9848284183
79	Madan Bahadur Rawat	Helper	9848064272
80	Yam Bahadur Thapa	Helper	9848241900
81	Dammar Shahi	Helper	9848399540
82	Ganesh Bahadur Rokaya	Helper	9815565407
83	Bishnu Bohora	Helper	9815561044
84	Lok Bahadur Bohora	Helper	9863189069
85	Kamala Bohara	Helper	9868175888
86	Kamal Prasad Koirala	Helper	9848141702
87	Ram Bahadur Rawal	Helper	9818499010
88	Bindra Shahi	Helper	9844892255
89	Janaklal Sunar	Helper	9804572173
90	Manju Nepali	Helper	9825561738
91	Puspa Sunar	Helper	9802569149
92	Ratna Khatri	Helper	9802559150
93	Man Kumari Khatri	Helper	9844899062
94	Devu Shrestha	Helper	9816568462
95	Bam Bahadur Rawal	Helper	9814597041
96	Jhalak Rawal	Helper	9828578067
97	Rajesh Khatri	Helper	9868122880
98	Padma Shahi	Helper	9812577438
99	Nandra Khatri	Helper	9866897026
100	Harikala Bogati	Helper	9748034077
101	Purna Bahadur Khadka	Helper	9824554398
102	Chakra Bahadur Basnet	Helper	9745514433

S.N.	Name/Surname	Designation	Phone Number
103	Narayan Bisunke	Helper	
104	Mina Kumari Khadka	Helper	
105	Pabitra Khatri	Helper	

IV. Contact Details of Health Facility Chief

Health facility name	Ward	Name	Phone number	Latitude	Longitude
Narayan Municipality					
Kuikana BHSC	1	Tej Bahadur Thapa	9848252955		
Narayan HP	2	Indra Bahadur Thapa	9848047273	28.8564949	81.70926443
Belaspur HP	3	Sita Sharma	9868182132	28.8629652	81.72282151
Belaspur Ayurved Centre	3	Rajiv Kumar Bharati	9858033964		
Sota BHSC	4	Bhawana Thapa	9846688972	28.89271642	81.75458669
Dewalkanda CHU	4	Rashmi Thapa	9866860626		
Tribeni HP	5	Sadananda Jaishi	9848242409	28.87966	81.742804
BHSC-6	6	Padam Kumari Budha	9848121807	28.85247	81.717572
Kadachaur UHC	6	Bhagawati Khadka	9841077205		
Basantamala HP	7	Prem Bahadur Bisunke	9844831759	28.842089	81.72526966
HSO Dailekh	8	Dr. Ratna Bir Sunar	9858023564	28.826008	81.71009
Simada UHC	8	Shanti Giri	9868166097	28.82501898	81.73483177
Sadu BHSC	9	Bhupendra Sharma	9843331483	28.813548	81.699002
Bhawani HP	10	Dhan Bahadur Basnet	9848116881	28.926571	81.742783

Health facility name	Ward	Name	Phone number	Latitude	Longitude
Bindyabasini HP	11	Chadra Bahadur BK	9848068947	28.84720114	81.76712147
Chamunda Bindrasaini Municipality					
BHSC Simser	1	Nanda Kumari Shahi	9841134041	28.97845882	81.5972443
BHSC Chalne	2	Dil Bahadur Sijali	9858050634	28.96392634	81.59620224
Chamunda HP	3	Khagendra Bahadur Shahi	9841111944	28.95923559	81.56317549
Roshani danda BHSC	4	Indra Kumari Shahi	9849362871	28.92769961	81.59154942
Chhadekhola BHSC	5	Radha Shahi	9845801751	28.93254189	81.54458292
Jambukandh HP	6	Jarma Kumari Shahi	9868071822	28.925411	81.546874
Mastamandu BHSC	7	Sunita Shahi	9861680652	28.90991715	81.50958887
Lyati Bindarasaini HP	8	Hikmat Bhandari	9848290055	28.908745	81.523408
Ringroad BHSC	9	Rabina Upadhayaya	9864792171	28.8925464	81.5225385
Dullu Municipality					
Deutichaur BHSC	1	Madan Kumar Khadka	9864333268		

Health facility name	Ward	Name	Phone number	Latitude	Longitude
Naulekatuwal HP	2	Khemraj Thapa	9848069549		
Nepa HP	3	Amrit BK	9858089999	28.86654168	81.56710572
Siyala UHC	3	Shanta Acharya	9848399690		
BHSC-4	4	Om Prasad Upadhayay	9844870642		
Riju BHSC	5	Sita Bist	9822536037	28.82843903	81.60781825
Dullu Hospital	5	Dr. Dipendra Ray	9849760106	28.85303331	81.60367453
Aayurved Aaushadhalaya	5	Madan Kumar Khadka	9864933268		
Chhiudi Pusakot HP	6	Dip Bahadur Khadka	9848030114	28.82793458	81.63074772
UHC Basnepati	6	Tara Khadka	9847850635	28.816841	81.61523586
Bahungaun BHSC	7	Laxmi Dahit Acharya	9868266223	28.89589838	81.62548199
Badalamji HP	8	Man Bahadur Thapa	9868647989	28.88401	81.592407
Paduka HP	9	Indramani Rokaya	9868647989	28.83466248	81.64258227
Gamaudi HP	10	Nabin Khadka	9858036540	28.80556498	81.66414606
Kalbhairab HP	11	Maheshwori Panta	9848120221	28.78006805	81.66373226
Gauri HP	12	Yagya Raj Bhandari	9858050309	28.788882	81.627092
Malika HP	13	Nagendra Sapkota	9822576994	28.793437	81.652073

Health facility name	Ward	Name	Phone number	Latitude	Longitude
UHC Binayak	13	Milan Bhandari	9849766257	28.85774221	81.58191541
Bagaura BHSC	4	Om Prasad Upadhayaya	9844870642		
Aathbis Municipality					
Satalla HP	1	Dhurbaraj Bist	9858051433	28.95213896	81.47819187
Sigaudi HP	2	Lokendra Bahadur Singh	9868656366	28.99035	81.454246
Nimayal BHSC	3	Debendra Jaishi	9848162551	29.01748457	81.44760672
Rakam Karnali Basic Hospital	4	Kiran Bahadur Saud Majhi	9868000446	29.060049	81.456047
Pipalkot HP	5	Madan Bahadur Rokaya	9864980548	29.083178	81.524982
Singhasain HO	6	Binod Kathayat	9848203775	29.052505	81.501566
Omkana BHSC	7	Pabitra Bogati	9868001389	29.039824	81.485916
Tilepata HP	8	Sikendra Mahato	9762756460	29.021677	81.479381
Chhepadi BHSC	9	Prashant Sijapati	9866230490	29.02430883	81.51716074
Thantikandh Rural Municipality					
Lakandra PHC	1	Dr. Manoj Kumar Shah		28.968429	81.525411
Pyaduli BHSC	2	Tanka Bahadur Shahi	9844280806	28.98793691	81.54375832

Health facility name	Ward	Name	Phone number	Latitude	Longitude
Bisala HP	3	Rashmi Pun Magar	9841987094	29.00631116	81.57354152
Bisala CHU	3	Jagat Bahadur Shahi	9848487199	28.98515	81.565125
Bisala BC Majkharka	3	Nira Kumari Shahi	9867871971	28.99628824	81.59353749
Gairagaun BHSC	4	Shumsher Babu Kathayat	9863123463	29.02104412	81.56172306
Tolijaisji HP	5	Kuber Khadka	9863839345	28.99285257	81.49813074
Angaldanda BHSC	6	Dharmaraj Rokaya	9845218335	28.98513997	81.5188481
Dungeswor Rural Municipality					
Belpata HP	1	Pooja Shahi	9843711173	28.799940	81.688944
Lakuri HP	2	Bal Krishna Bisht	9848067675	28.776178	81.715989
Aawalparajul HP	3	Ammar Bdr. Sapkota	9858049355	28.713055	81.721111
Baunnechaur BHSC	4	Jagat Kumar B.C.	9848076383	28.729752	81.699327
Dandaparajul HP	5	Ram Prasad Neupane	9848159025	28.753643	81.688087
Dungeshwor BHSC	6	Prakash K.C.	9864734298	28.762999	81.664449
Naumule Rural Municipality					
Toli HP	1	Amrit Pr. Neupane	9844832197	28.897172	81.778548

Health facility name	Ward	Name	Phone number	Latitude	Longitude
Baluwatar HP	2	Dipak Raj Sharma	9848039105	28.932598	81.809566
CHU Kagate	2	Basant Sapkota	9812550009	28.974112	81.773031
Dwari HP	3	Jagat Prasad Koirala	9815502339	28.941422	81.824928
Kalika HP	4	Min Bahadur Gurung	9848076294	28.912849	81.866842
Naumule PHC	5	Dr. Narayan Sharma	9749724148	28.906257	81.810478
Salleri HP	6	Ganesh Pr. Gautam	9844865001	28.877868	81.804306
BHSC Paiti	7	Sarita Ku. Bisht	9868212494	28.859530	81.832355
Chauratha HP	8	Dhan Bahadur Chand	9860657633	28.860454	81.789677
Mahabu Rural Municipality					
Kharigaira HP	1	Bishnu Thapa	9858055003	28.895897	81.696268
Badakhola HP	2	Ram Bahadur Thapa	9848284462	28.878212	81.685349
CHU Airadi	2	Ganesh Bahadur Bhandari	9848196526	28.887509	81.677301
Bansi HP	3	Prem Bahadur Bisht	9848078948	28.911982	81.666174
Mahabu Hospital	4	Surendra Singh	9848211418	28.928444	81.690218
CHU Gita Chuar	4	Rajesh Hamal	9742591968	28.936245	81.664930
Kansikandh HP	5	Karn Bahadur Baral	9849312996	28.964667	81.665702

Health facility name	Ward	Name	Phone number	Latitude	Longitude
CHU Yekpate	6	Hem Bahadur Bisht	9858068250	28.970024	81.699630
CHU Takuri	6	Akkal Bahadur Shahi	9858030903	28.957553	81.710933
Bhairabi Rural Municipality					
BHSC Rawatkot	1	Madan Bahadur Thapa	9815579504	28.91935	81.65033
Rawatkot HP	2	Sher Bahadur Karki	9843808397	28.87892	81.64599
BHSC Badalamji	3	Prem Bahadur B.K.	9844862118	28.90145	81.63176
Bhairikalikathum HP	4	Karunakar Khatri	9848114979	28.92705	81.62438
BHSC Dokra	5	Hari Bhatt	9869979596	28.93056	81.64771
BHSC Duisalle	6	Ganesh Adhikari	9848069224	28.95312	81.64195
Kusapani Health Post	7	Birendra Raj Shahi	9858070622	28.99666	81.63257
CHU Jumlikabari	4	Purna Bahadur Shahi	9866218627	-	-
CHU Panipokhara	7	Arjun B.K.	9844857859	28.97123	81.63355
Gurans Rural Municipality					
Septi Basic Health Service Center	1	Om Prasad Rijal	9844861887	28.73879	81.58077

Health facility name	Ward	Name	Phone number	Latitude	Longitude
Puraini Basic Health Service Center	2	Kiran K.C.	9848049558	28.77186	81.60107
Seri Health Post	3	Krishna Rokaya	9848221019	28.73029	81.62019
Khadkawada Health Post	3	Prem Prasad Bhattarai	9848025036	28.75843	81.59932
Seriwada Health Post	4	Janak Chapai	9858052050	28.74377	81.62975
Goganpani Health Post	5	Hem Bahadur Gurung	9848079128	28.68530	81.63524
Guras Hospital	5	Jagat Bahadur Thapa	9848284303	28.70138	81.67374
Sanakanda Community Health Unit	5	Nisha Rijal	9848037791	28.69650	81.69822
Piladi Health Post	6	Jeevan Magarati	9848195500	28.68278	81.73129
Lalikanda Health Post	7	Nirmala Basnet	9868911659	28.68417	81.77084
Dharampokhara Basic Health Service Center	8	Krishna Sudha Dhungana	9867312733	28.64553	81.78038
Bhagawatimai Rural Municipality					
Pagnath HP	1	Durga Gurung	9863157404	28.79678	81.80921
Ayurveda Arogya Service Center	1	Dinesh Kumar Thapa	9868997708	-	-

Health facility name	Ward	Name	Phone number	Latitude	Longitude
Bestada Birthing Center	2	Khambira Thapa	9868113666	28.78734	81.83052
Room Health Post	2	Bhavisara Shahi	9848031439	28.811	81.83817
Meheltole HP	3	Mahendra Kumar Bharti	9848041689	28.81675	81.8508
Bhagwatimai Basic Hospital	3	Dr. Bijay Bhusal	9843620374	28.79009	81.85058
Jagnath HP	4	Bhim Bahadur B.C.	9864942436	28.78555	81.86913
Katti HP	5	Sarjan Gurung	9858089800	28.77482	81.82566
Chipin HP	6	Amar Singh	9844813009	28.77437	81.80841
Badabhairab HP	7	Hikmat Khatri	9848121595	28.78316	81.7637