REPORT ON
AUDIT OF STRONG AND RESILIENT NATIONAL PUBLIC HEALTH SYSTEMS
(RELATED TO SDG TARGET 3.D.)

(SPECIAL AUDIT REPORT, 2079)

Office of the Auditor General Nepal
Anamnagar, Kathmandu

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Chapter 1 – Background

1. Background:

As per the international commitment to Agenda 2030, Nepal needs to achieve Sustainable Development Goals (SDGs) by 2030. A 25-year Vision has been formulated which aims to attain the SDGs by 2030 and reach the level of developed countries by 2043. Also, the Fifteenth periodic plan (2019/20-2023/24) has been formulated which again aims of achieving the SDGs by 2030.

SDGs comprise of 17 different goals. Goal 3: **Ensure healthy lives and promote well-being for all at all ages** is primarily linked with the health sector. Goal 3 target 3.d. **Strengthen the capacity of all countries, in particular, developing countries, for early warning, risk reduction, and management of national and global health risks** is related to The World Health Organization (WHO) International Health Regulation (IHR) Implementation as its indicator 3.d.1. is stated as "International Health Regulations (IHR) capacity and health emergency preparedness". Starting from the baseline figure of 77 based on the WHO Assessment Report (2015), Nepal aims to reach to 95 by 2030.

Nepal, being a member of the WHO since 1953, is liable for the IHR, 2005. WHO Country Office has been supporting the Government of Nepal (GoN) by technically assisting the government in achieving existing goals and targets. The purpose and scope of the International Health Regulations (2005) are "to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade". Because the IHR (2005) are not limited to specific diseases but applies to new and ever-changing public health risks, they are intended to have long-lasting relevance in the international response to the emergence and spread of disease. The IHR (2005) also provides the legal basis for important health documents applicable to international travel and transport and sanitary protections for the users of international airports, ports, and ground crossings.

The National Planning Commission (NPC) being the government focal agency for the 2030 Agenda and the SDGs has prepared different strategies and reports regarding the SDGs. The first voluntary national review (VNR) report had been prepared by NPC and presented to the United Nations High-Level Political Forum in 2017. On June 2020, Nepal published its VNR2020. However, many stakeholders including Nepal SDGs Forum have openly expressed their doubts saying that based on the preliminary data and situation, most of the SDG targets and indicators seem unachievable if the current trend goes on.

This report has been prepared based on the practice of conducting performance audits by the Supreme Audit Institution regarding the Implementation of SDG. The report describes policies, institutions, organizations, and human capacity-related challenges to implementing SDG target 3.d. It also analyses the budget and resources along with the arrangement for monitoring keeping the coherence perspective and giving focus to Leave No One Behind (LNOB) and Multi-Stakeholder Engagement. It has attempted to assess the progress made towards meeting the milestones and the target ultimately and also recommend some way forward.

Chapter 2- Audit Objective, Scope and Methodology

2. Audit Objectives:

The primary objective of this audit is to prepare an SDG implementation Report based on the assessment of the government's efforts at strengthening the health system's capacities to forecast, prevent and prepare for public health risks to effectively meet SDG 3.d targets related to public health resilience.

The specific objectives of the audit are to:

a) assess the legal and policy frameworks and institutional arrangements to enhance capacities to forecast, prevent and prepare for public health risks;
b) assess the government's efforts and capacities to manage the required resources for strengthening the health system's capacities to forecast, prevent and prepare for public health risks;
c) examine the efforts of the government on assessment of the risks, monitor, evaluate and report on its current capacities to forecast, prevent and prepare for public health risks;
d) assess the adequacy/relevance of the indicator used; and assess the progress made towards SDG target 3.d.

3. Scope of Audit:

The audit being basically based on desk review covers the period from 2016 onwards. As a case study, taking a recent public health issue, COVID -19 as a reference, we have included in our scope the issues of coherence, Leave No One Behind, Multisectoral engagement especially related to COVID along with the overall aspects of the public health sector. Though the audit was conducted on a sample basis it is expected to have covered the issues of all the provinces, and local levels along with the federal as far as possible.

4. Audit Methodology:

This report has been prepared by applying a descriptive approach. Secondary data from different sources especially the published reports of different UN Agencies, International Non-Government Organizations, Constitutional bodies, Ministries and other agencies of the Government of Nepal (GoN). Some Non-Government Organization's reports, research reports, media reports, and scholarly journals have also been consulted. A case study regarding prevention, control, and treatment of COVID has also been conducted as a recent public health emergency faced by the country as well as the whole world. Since various entities are involved in every SDG Goal, in addition to the norms, guidelines and international best practices adopted by the Office of the Auditor General Nepal (OAGN) in this audit, the guidelines issued by the International Organization of Supreme Audit Institutions (INTOSAI) and the methods and procedures mentioned in the Performance Audit Guidelines prepared by the OAGN have been followed as required.

In course of the audit, though limited in number, documents and data were collected through the questionnaire face-to-face interviews as well as telecommunication with the relevant authorities as well and were reviewed, discussed, and interacted with relevant stakeholders. The report has been prepared based on the analysis of the information received.

5. Limitation of Audit:

The audit has been performed with the optimum use of available resources. Mobilizing the audit team while paying due attention to the health concerns was challenging. Hence, the report is basically based on the study and the analysis of the secondary source data which are primarily accessed through publicly available reports published by relevant government and non-government institutions. As the information had to be collected from a large number of entities, the report has been prepared by testing samples available.

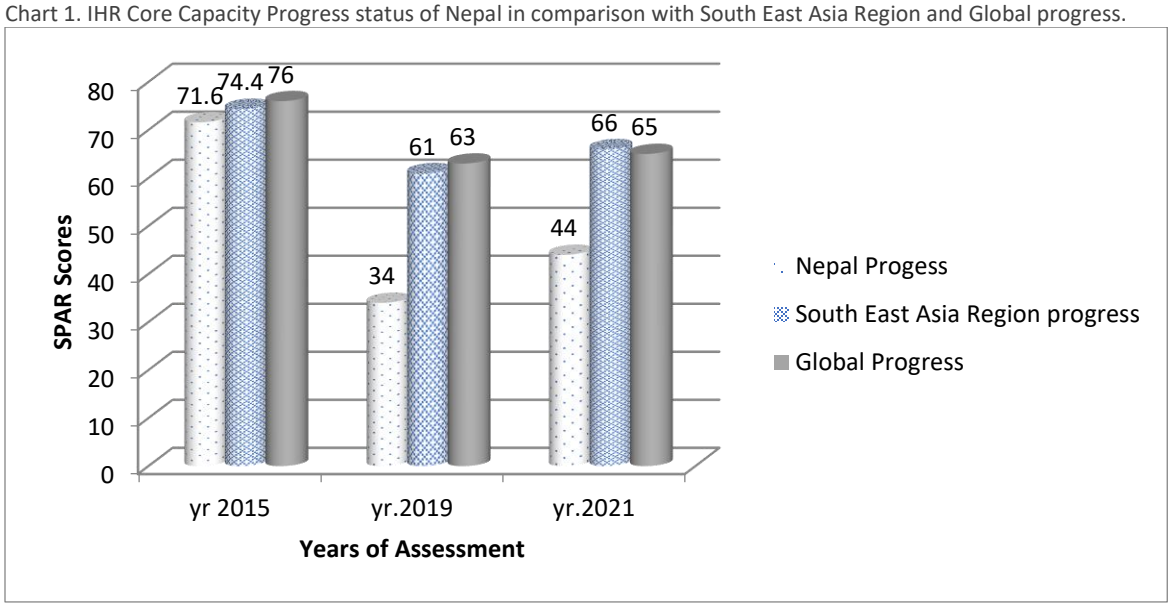
Chapter 3- Audit Observations

6. Target 3d Progress:

Target 3.d. for Nepal is totally related to IHR capacity scores as it has adopted indicator 3.d.1. only. The baseline data of the indicator is as per the WHO assessment report of 2015 i.e., 77. IHR prescribes different mechanisms for Monitoring the progress toward IHR compliance. And most renowned ones are the SPAR (State Party Self-Assessment Annual Report) and the JEE (Joint External Evaluation). As Nepal is among those countries whose JEE has not been conducted since 2016, SPAR is the only measurement that can be used for assessment of the IHR compliance. Being a self-assessment, it is subject to a certain level of bias. However, many studies have shown a close correlation between SPAR and JEE scores.

Further, the indicators and the core capacity score index have been changing with time. Recently, in the year 2021, the number of core capacities was changed to 15 from 13. The indicators have also been added and hence, the analysis of the trend of progress has become a bit cumbersome as this has impacted the comparability of data. Yet, based on the available data, the following graph has been developed which shows the scores of Nepal, South East Asia Region average along with the Global average.

Chart 1. IHR Core Capacity Progress status of Nepal in comparison with South East Asia Region and Global progress.

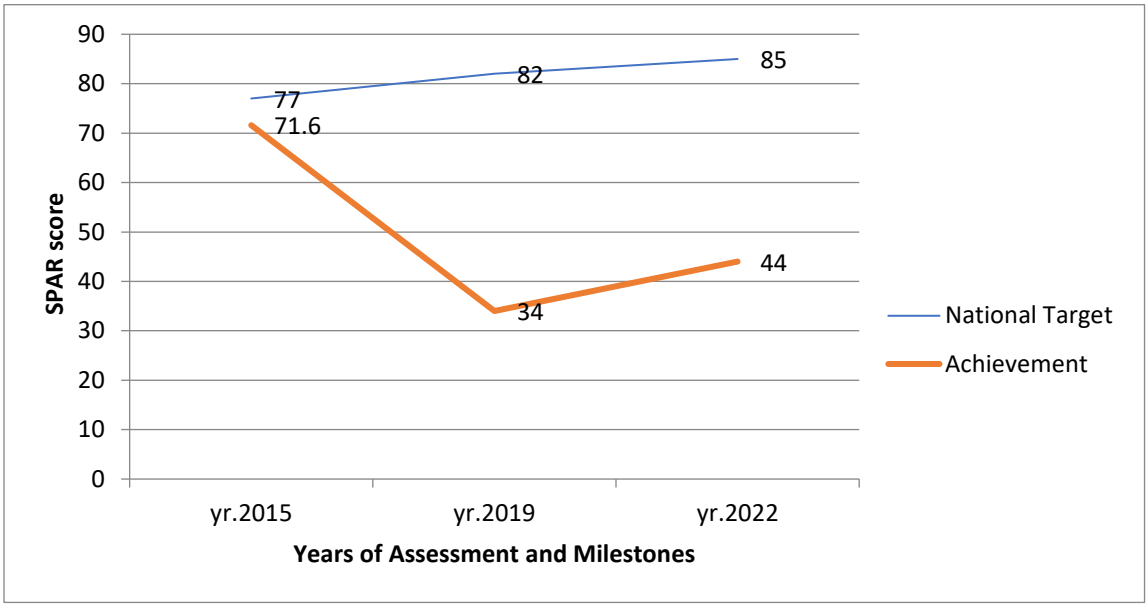


source: https://extranet.who.int/e-spar

Taking the SPAR data as a reference, the baseline data of 2015 i.e., 71.6 is somewhat near to that of the WHO Assessment Report (2015) i.e., 77, hence the data corresponding to 2019 and 2021 are assumed to reflect the picture that would be acquired if measured by WHO. While based on the SPAR data, the global, as well as regional averages, seem to have lowered from the level at 2015 but comparatively, Nepal's score seems to have lowered with much difference in 2019. Slight progress is seen in 2021 in all three, and here Nepal's progress percentage is remarkable as compared to that of regional and global averages. The trend seems to be favorable. But, still, it is

much below the milestones and the ultimate target set. Hence, the comparison between the NPC's roadmap data and SPAR data has been made and presented below.

Chart 2. Comparison of IHR capacity progress status of Nepal (based on SPAR) with milestones targeted by the National Planning Commission, Nepal.



Lack of data and delay in the external evaluation of IHR capacity progress has led to a data gap and the SDG progress reports and VNRs are not able to include the data related to target 3.d. There is a need for a reliable progress assessment as soon as possible.

7. Policy and Legal Provisions:

The Constitution of Nepal has the provision of the right to get free basic health services from the state as a fundamental right of the citizens of Nepal.

In the fundamental rights and duties section of the Constitution, the rights of the citizens or targeted segments of the population are defined under different themes including those related to health. Some examples are listed as follows:

i. Section 18. Right to Equality: (2) No discrimination shall be made in the application of general laws on grounds of origin, religion, race, caste, tribe, sex, physical condition, disability, condition of health, marital status, pregnancy, economic condition, language or region, ideological conviction or on similar other grounds.

ii. Section 35. Right relating to Health: (1) Every citizen shall have the right to free basic health services from the State, and no one shall be deprived of emergency health services. (2) Every person shall have the right to get information about his or her medical treatment. (3) Every citizen shall have equal access to health services. (4) Every citizen shall have the right of access to clean drinking water and sanitation.

iii. Section 38. Rights of Women: (5) Women shall have the right to obtain special opportunity in education, health, employment and social security, on the basis of positive discrimination.

iv. Section 39. Rights of Child: (2) Every child shall have the right to education, health, maintenance, proper care, sports, entertainment and overall personality development from the families and the State.

v. Section 40. Rights of Dalit: (3) Special provision shall be made by law in order to provide health and social security to the Dalit community.

vi. Section 42. Right to Social Justice: (2) The indigent citizens and citizens of the communities on the verge of extinction shall have the right to get special opportunities and benefits in education, health, housing, employment, food and social security for their protection, upliftment, empowerment and development. (5) The families of the martyrs who have sacrificed their life, and of the disappeared persons and those who became disabled and injured in all people's movements, armed conflicts and revolutions that have been carried out for progressive democratic changes in Nepal, democracy fighters, conflict victims and displaced ones, persons with disabilities, the injured and victims shall have the right to get a prioritized opportunity, with justice and due respect, in education, health, employment, housing and social security, in accordance with law.

At the Federal level, the Federal Ministry of Health and Population (FMoHP) developed the National Health Policy, 2076 (2019), in light of the new constitution of the country. The Public Health Service Act has also been enacted by the federal parliament to operationalize the constitutional rights of citizens for health service provision. Moreover, the FMoHP has defined the package of basic health services as an integrated part of the public health services regulations and has been approved on September 2020.

At the Provincial level, Karnali Province and Gandaki Province have developed their provincial health sector policy;

At the Municipal level, some local governments have also developed policies or laws to govern the health sector.

However, regarding target 3.d., there is no specific policy as IHR is a concept that incorporates many different aspects of Health.

Public Health emergencies are also the subject of Disaster Risk Reduction and Management Policy. Nepal has been adopting Sendai Framework (2015-2030) as well. Disaster risk reduction and management is the business allocated to the Ministry of Home Affairs (MOHA).

The NPC document Nepal Sustainable Development Goals Status and Roadmap:2016-2030 clearly states that the Ministry of Health and the WHO as the Responsible Agencies for indicator 3.d.1. in its details of targets and indicators for Goal 3. However public health emergency preparedness is again an inevitable part of disaster risk reduction and management. Thus, it is recommended that MOHA be added as the agency responsible for indicator 3.d.1.

Nepal has its National Policy for Disaster Risk Reduction, 2018 endorsed by the Disaster Risk Reduction and Management (DRRM) National Council's decision in line with the provision mentioned in the Disaster Risk Reduction and Management Act, 2017. It provides for different roles to all three tiers of the government. It prescribes for Disaster Management Committees at Province, District and Local levels and they have been formed. At the National Level, there is already the National Disaster Risk Reduction and Management Authority (NDRRMA).

The spirit of the Constitution suggests that local governments shall do as much as they can on their own, and where they cannot, provincial and federal governments shall provide backup or lead disaster risk reduction and management. However, the spirit is not well reflected in DRRM

Act and other legal provisions and the ambiguity has created confusion about roles, responsibilities and accountability between these three levels.

Further, a Disaster Risk Reduction National Strategic Plan of Action 2018 – 2030 has also been formulated. It provides a comprehensive planning framework for disaster risk reduction and management in Nepal, encompassing different priority areas and guiding government actors and stakeholders to achieve targets by adopting appropriate processes. It has emphasized on coordination of all three levels of government along with the private sectors. Yet, it lacks to cover the issues that hamper public health like food safety, chemical events and radiation emergencies. Though it has included epidemics among the list of disasters, it was found insufficient to address the issues of COVID- 19 which demanded separate Preparedness and Response Plan, though there are already Disaster Preparedness and Response plans in federal, as well as local levels including districts.

7.1. Vertical Coherence:

The Constitution of Nepal 2015 indicates easy, convenient, and equal access to quality health services for all citizens. Therefore, realizing this provision through policy and the legislative document is essential.

Further, Constitution also provides for different rights to the different levels as stated in Annex 5-9. There are two types of rights: exclusive rights and concurrent rights. The rights as defined in the Constitution appear to be relatively broad covering a wide scope. Nevertheless, the Constitution says that those rights are to be executed in accordance with the constitutional provisions and as per the laws of the concerned level. Health and population-related constitutional provisions regarding the rights of federal, provincial, and local levels are listed in the Table below.

Table 1. Constitutional provisions regarding the distribution of state power towards the health sector.

Level	Description of rights	Related clause/annex
Federal (Exclusive)	Health policy, health services, setting standards, quality and monitoring of the health services, national/specialized service providing hospitals, traditional treatment services, control of communicable diseases	Clause 5 (1) and Annex 5
Province (Exclusive)	Health service	Clause 57 (2) and Annex 6
Federal and Province (Concurrent)	Medical, Ayurveda, Aam chi and the other professionals Insurance operation and management	Clause 57 (3) and Annex 7
Local Level (Exclusive)	Basic health and sanitation	Clause 57 (4) and Annex 8
Federal, Province and Local Level (Concurrent)	Health Registration of personal incidents, birth, death, marriage and statistics	Clause 57 (5) and Annex 9

Source: *2020 Analysis of FAA and Health Policy (UKAID, NHSS)*

Besides exclusive and concurrent rights, the constitution makes the provision of residual rights stating that "powers relating any subject that is not mentioned in the list of powers of the federation, province or the local level entity, or in the concurrent powers of the federation and the province, or not stated in this constitution shall rest with the federal level as the residual powers". Similarly, regarding fiscal power, which is an important aspect to accomplish the defined functions for any sector, the Constitution has mandated federal, provincial, and local entities to

enact laws, make annual budgets and necessary decisions, formulate policies and plans, and implement them at the respective level.

To help clarify roles and responsibilities, and in accordance with the constitutional provisions, the mandates for different levels of government are elaborated in two documents. The Functional Analysis and Assignments (FAA) specifies mandates across all three governments. The FAA is approved by the federal government (Cabinet level) and is a useful starting point for delineating respective roles and responsibilities. However, the FAA is not an Act and therefore does not carry legal force. For the local level, however, the federal parliament has promulgated the Local Government Operation Act (LGOA) which, with legal force, defines roles, responsibilities, and rights of the local governments along with other provisions in relation to the operation of local government.

There is no specific policy, strategies or guidelines specifically linked to forecasting, prevention and preparing for the public health risks developed totally in the initiation of the provinces themselves. The policies designed at federal level needs to be internalized by the provinces and the local level. As each level of government is independent in itself, it is still a challenge to achieve national target in this new system.

7.2. Horizontal Coherence:

The Ministry of Agriculture and Livestock Development (MoALD) in collaboration with MoHP has developed One Health Strategy, 2020 which is expected to address the coordination issues regarding the Human-Animal interface which is expected to play role in controlling zoonotic diseases.

The emergency situations like COVID-19 demand for nimble decision-making by different agencies at different levels and flexible financing should also be on standby for effective response to the emergency. However, there is no such arrangement that allows for quick and perfectly informed decisions regarding public health risks.

Delay in the formulation of the Federal Civil Service Act, which would be the umbrella law to govern the provincial civil service law, has led to a gap in the fulfillment of different health-related manpower in the Federal Agencies. This further led to delays in the provincial Civil Service Act which again hampers Human Resource fulfillment and causes a scarcity of Human resources to address the needs during forecasting, prevention, and preparing for public health risks.

7.3. LNOB and Multi-sector Engagement:

Reaching the Unreached Strategy, (2016-2030) has been developed by the federal government. It is expected to support Universal Health Coverage (UHC). It has stated 8 objectives. All the objectives are basically meant for enhancing the access to and utilization of health services by all including women, socially excluded groups, ethnical/religious minorities, poor and marginalized, people living in remote areas, homeless children, immigrant labours, differently-abled people, HIV infected LGBTI and the other people who don't have access to quality basic health services. Yet, it lacks the perspective of federalism and assigns no role to the sub-national governments.

And again, there are no provisions specifically meant for the forecasting of public health risks. Immunization is the one issue that addresses the prevention aspect whereas, towards the preparedness aspect, it has mentioned strategies like telemedicine, free ambulance,

infrastructure development, Human Resource Management, multi-sectoral involvement, involvement of NGOs/INGOs, risk communication along with monitoring. Karnali Province which has the second lowest HDI (Human Development Index) among 7 provinces, has also developed its own Reaching the Unreached Strategy in line with the national strategy. No such specific strategies to address the needs of unreached population were found in other provinces.

8. Institutional Arrangements:

A High-level steering committee chaired by the Prime Minister, an SDGs Implementation and Monitoring Committee coordinated by the Vice-Chair of the National Planning Commission (NPC), and a Thematic Working Committee coordinated by the members of the NPC have been formed for the implementation and monitoring of the SDGs. These committees are expected to guide the implementation, monitoring, and evaluation of the plans, programs, policies, and financing related to the SDGs. The Social Development Committee is particularly responsible for Goal 3.

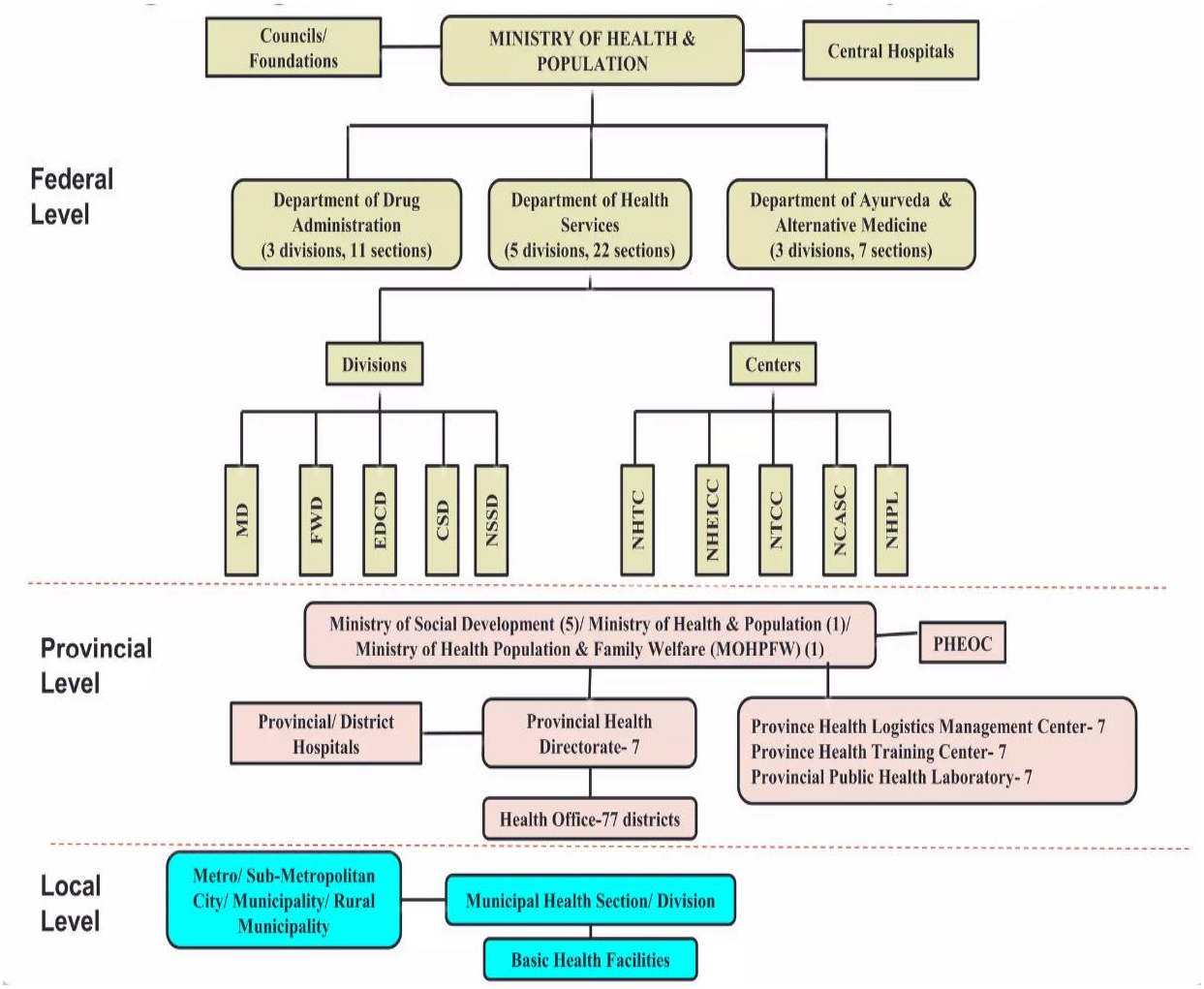
The Government of Nepal Rules for Allocation of Business of Ministries clearly states that the responsibility towards international health regulation is of Federal Ministry of Health and Population. It is the duty of the MoHP to draft its policies in line with the IHR (2005) and also to make the provinces and local levels work accordingly. There is no specific policy regarding target 3.d in the provinces. In fact, the baseline reports of SDGs prepared by the provinces do not include target 3.d. Hence, the Federal MoHP seems solely responsible towards target 3.d.

In terms of Health Emergencies like disease outbreaks and epidemics, Department of Health Services (DoHS) has a separate Division named Epidemiology and Disease Control Division (EDCD) which is also responsible for EWARS (Early Warning, Alert and Response System) which collects data related to the detection of disease outbreaks from different sentinel sites. However, the data in EWARS could not be up to date due to delay in reporting by the sites.

EDCD is also the national focal point for IHR (2005). It has been reported through the state party self-assessment portal (e-SPAR) of WHO which is the only data related to IHR capacity scores and progress as there has been no external evaluation of IHR compliance after 2015. This has caused a huge data gap.

The health sector at all the federal and local level was present before federalism and hence are comparatively more stable and robust. The central government and the local level had been conducting different health-related programs like vaccinations, and safe motherhood for a long period and hence there is good coordination. The FCHVs (Female Community Health Volunteers) had been mobilized for a long time and they have been playing a very important role in providing health services to the community, especially in rural areas. The organizational structure of the Health System has been a bit modified after federalism to address the roles assigned to all three levels of government. To enhance Universal Health Coverage, and support the Reaching the Unreached Strategy the Health Service Providers at the ward level are present and functional. The same structure is equally responsible for public health risk management.

Figure 1. The organogram of the public health service structure of all three levels is as presented in the below diagram



Source: *https://www.slideshare.net/PrabeshGhimire/organogram-organization-structure-of-nepalese-health-system-updated-nov-2021*

8.1. Vertical Coherence:

As per the list of exclusive and concurrent powers enumerated by the Constitution, the functions of formulating health policy and standards, ensuring quality and monitoring, traditional treatment services and infectious disease control have been assigned to the federal government whereas the responsibility of health services have been assigned to the federal, provincial and local levels. For its effective implementation, inter-ministry coordination and collaboration is a must.

Although coordination and cooperation between the three levels is essential, no coordination was noticed between the provincial government and the local levels and the federal ministry in resource mobilization, manpower management and information communication. Since the governments at each level are independent and the spirit of Constitution doesn't allow direct

control of one level of government to the other, in some cases there is a problem of duplication in the operation of public health-related activities.

The health service structures are linked to each other by Health Management Information System (HMIS). The HMIS on the previous (District Health Information Software 2) DHIS2 platform has been updated to accommodate the latest federal structure. Health facilities now report on paper forms to the municipalities where data is entered electronically into DHIS2. The number of health facilities reporting electronically had expanded to over 1,200 facilities by the end of the fiscal year 2017/18. Private facilities are meant to report through the municipalities. However, many facilities continue to report to the Provincial Health Office in the district, adding to the fragmentation in information management.

Due to a lack of clarity on, and capacity for, data management, the reporting from municipalities is often late, incomplete, poor in quality, or non-existent in some cases. The use of data and evidence from the information system at the local level remains poor. There is a disjoint in reporting to provincial and districts levels, which are bypassed in the reporting system.

8.2. Horizontal Coherence:

Disaster Risk Reduction and Management Act, 2074 has been implemented with the objective of protecting the livelihood of the people from natural and non-natural disasters by managing all disaster management activities in a coordinated and effective manner. According to the Act, non-natural disasters include pandemics, famines, fires, insect or microbial terror, flu in animals and birds, and pandemic flu. The Act has established the National Council for Disaster Risk Reduction and Management under the chairmanship of the Prime Minister, the Executive Committee under the chairmanship of the Home Minister, the National Risk Reduction and Management Authority, the Provincial Disaster Management Executive Committee, District Disaster Management Committee and the Local Disaster Management Committee. The Ministry of Home Affairs has permanent facilities including the National Emergency Operations Center, the Ministry of Health and Population has Health Emergency Operation Centre and the Department of Health Services has Epidemiology and Disease Control Division. Despite the existence of these structures, COVID -19 Crisis Management Centre (CCMC) was established by the decision of the Council of Ministers, Government of Nepal on March 29, 2020, under the coordination of the Deputy Prime Minister, and subordinate Corona-19 Crisis Management Center has been established in Province, District and Local levels. Although there are permanent structures set up by law, temporary structures were added, which increased the number of the agencies, which led to difficulty in the jurisdiction of work and coordination.

The Ministry of Health and Population being the thematic ministry has a structural arrangement to prepare for other epidemics of general nature, moreover, preparedness was done at the initial stage of the pandemic; however, it was only after the formation of the High-Level Coordinating Committee and the COVID Crisis Management Center, work was carried out under their direction. It was noted that even though the conduction of the physical examination of Secondary Education Examination (SEE) was scheduled to be held on April 22, 2020, the Ministry of Education, Science and Technology postponed the exam only at the last moment due to the risk of infection.

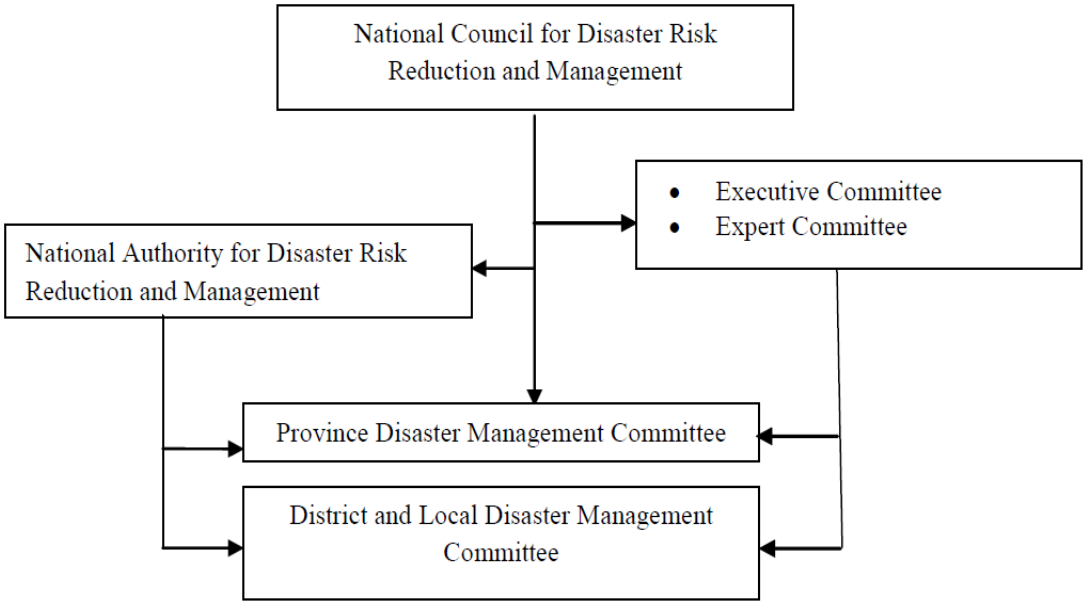
8.3. LNOB and Multi-sector Engagement:

The Constitution of Nepal 2015 clearly states every activity of all the levels of government should be guided by the principle of Inclusiveness.

Constitution also has provisions for Inclusive Commission, Dalit Commission, Women Commission, Muslim Commission, and National Human Rights Commission. Further, there is the Ministry of Women, Children and Senior citizens and along with that, there are non-state actors like Nepal Federation of Indigenous Nationalities, Blue Diamond Society, and regional and country offices of international Non- Government Organizations like Save the Children, etc. which are expected to continuously monitor the inclusion of all gender, age, indigenous people, religious minorities, disabled people, poor and marginalized in the policies and activities related to the forecasting, prevention and preparedness towards public health risks.

Towards Disaster Management, the institutional arrangement as prescribed by Disaster Risk Reduction and Management (DRRM) Act, 2017 is as follows.

Figure 2. The Disaster Risk Reduction and Management structure of all three levels as prescribed by DRRM Act



Source: *Nepal, P., Khanal, N.R., & Sharma, B. (2018). Policies and Institutions for Disaster Risk Management in Nepal: A Review.*

The DRRM Act 2074 (2017) sets out formal structures, roles and responsibilities at federal, provincial, district, and local levels. At federal level there is provision for a DRRM National Council, Executive Committee, and National Disaster Risk Reduction and Management Authority (NDRRMA). The First Amendment of the DRRM Act 2074 in 2075 (2019 AD) also includes a provision for a Province Disaster Management Council (Chapter 6, Clause 13Ka) and further specifies the structure and functions of Provincial Disaster Management Executive Committees.

The Act also stipulates a structure (a Disaster Management Committee) and DRRM functions for each local government. Local governments are also guided by the Local Government Operationalization (LGO) Act 2074 (2017 AD), which established disaster management structures and functions for each local government and their ward units.
Ministry of Home Affairs (MoHA) has also developed a web portal dedicated to disaster information called Nepal Disaster Risk Reduction Portal. It is a common portal that includes reports, publications, acts, rules and guidelines issued and published by all different levels of the government.
Further, there are Disaster Focal Persons allocated in 50 different agencies including the Federal ministries, major departments, security forces and other autonomous bodies as well.
Again, there is a National Emergency Operation Center (NEOC) at the national level, 6 Provincial EOCs, 70 District EOCs and 2 Municipal EOCs which work in coordination with different agencies to take actions related to response to emergencies.
NEOC also operates a SAHANA Disaster Management System which collects information like incident details, and loss assessment. However, it doesn't seem to have covered Public Health related data as an incident.

Especially, taking the institutional presence and coordination during recent pandemic of COVID - 19 as a reference, we have following as an example:

Inter-Agency Coordination in COVID - According to the Interim Directive for the operation of the COVID-19 case Research and Investigation Team, 2077 (2020), the local level has to mobilize the team, the provincial government has to conduct training and the central government has to analyze information; however, the Center for Crisis Management (CCMC) has been mandated with the overall authority to take a decision regarding COVID-19 and the Ministry of Health and Population has been assigned the task of implementation and monitoring. Due to the lack of proper coordination and cooperation between the Ministry of Health and Population and other thematic ministries, the provincial government and the local level, it has been difficult to achieve the expected results in the prevention and control of COVID-19. Some examples are as follows:

For control of the pandemic, security agencies, Ministry of Home Administration, Ministry of Health and Population, 7 Provincial Ministry of Social Affairs, Provincial Ministry of Internal Affairs, Chief Ministers, Office of the Chief Secretary and Council of Ministers, and local levels have been mobilized. Although Corona Prevention and Control High Level Coordinating Committee, COVID-19 Crisis Management Committee and the Federation were responsible for making policy decisions, many permanent structures were active in their respective responsibilities; as one structure did not control or direct another structure, there was difficulty in coordination. As a result, many policies formulated by High level Coordination Committee were not complied with at the provincial and local level.

As the cases of COVID-19 began to spread, in order to quarantine patients, the Government of Nepal initiated tracking and tracing activities and mobilized doctors, nurses and health technicians in public and private hospitals to update health protocols; moreover, COVID spread was categorized into four group as imported, local transmission, community spread, and beyond control. The health response report published by the

Ministry of Health states that it cooperated and coordinated with international and national non-governmental organizations, disseminated information to the public, supplied medical equipment and pharmaceutical supplies, provided essential services and supplies, and adhered to health protocols.

9. Planning:

The National Planning Commission (NPC) has been assigned the role of formulating the policies and preparing plans by the Executive Order for the Formation and Execution of National Planning Commission, 2018. It is responsible in determining the long-term vision, preparing periodic plans and formulating annual programs as well. In provincial level, there are Provincial (Policy and) Planning Commissions in each of the 7 provinces.

9.1. Vertical Coherence:

NPC has designed, published, disseminated and conducted orientation sessions to the people's representatives and related personnel of all the provinces and local levels about the Guidelines for planning development activities.

As per the guideline, Local level planning needs to be in line with the respective Province periodic plan developed by Provincial Planning Commission which again adheres to the National Level Periodic Plan developed by National Planning Commission.

It also guides the designing of the Medium-Term Expenditure Framework (MTEF) for all levels of government and ultimately the Annual Work Plan and Budget (AWPB)s of all.

The Ministry of Health and Population also publishes and disseminates guidance/basis for Health sector-related activities in AWPB for the provinces and the local levels.

9.2. Leave No One Behind (LNOB)

NPC being the focal point of SDG and the leading organization responsible for National Planning has incorporated the concept of leaving no one behind in all of its plans and programs. Hence, the fourteenth (FY 2017- FY 2019) and the fifteenth (FY 2019/20 – 2023/24) periodic plan both include the perspectives of LNOB.

9.3. Multi-sector engagement

A Working Committee led by the head of the Disaster Management Division of the Ministry of Home Affairs was formed for the preparation of the DRRM strategic plan of action. It comprised representatives from different government entities (Office of Prime Minister and the Council of Ministers, National Planning Commission, Ministry of Federal Affairs and General Administration, Ministry of Urban Development, Ministry of Health and Population, and Ministry of Forest and Environment) and development partners (Donor agency, Office of the UN Resident Coordinator, UNDP, Association of International Non-Governmental Organization Task Group on Disaster Management, Disaster Preparedness Network Nepal, Nepal Red Cross Society, and private sector).

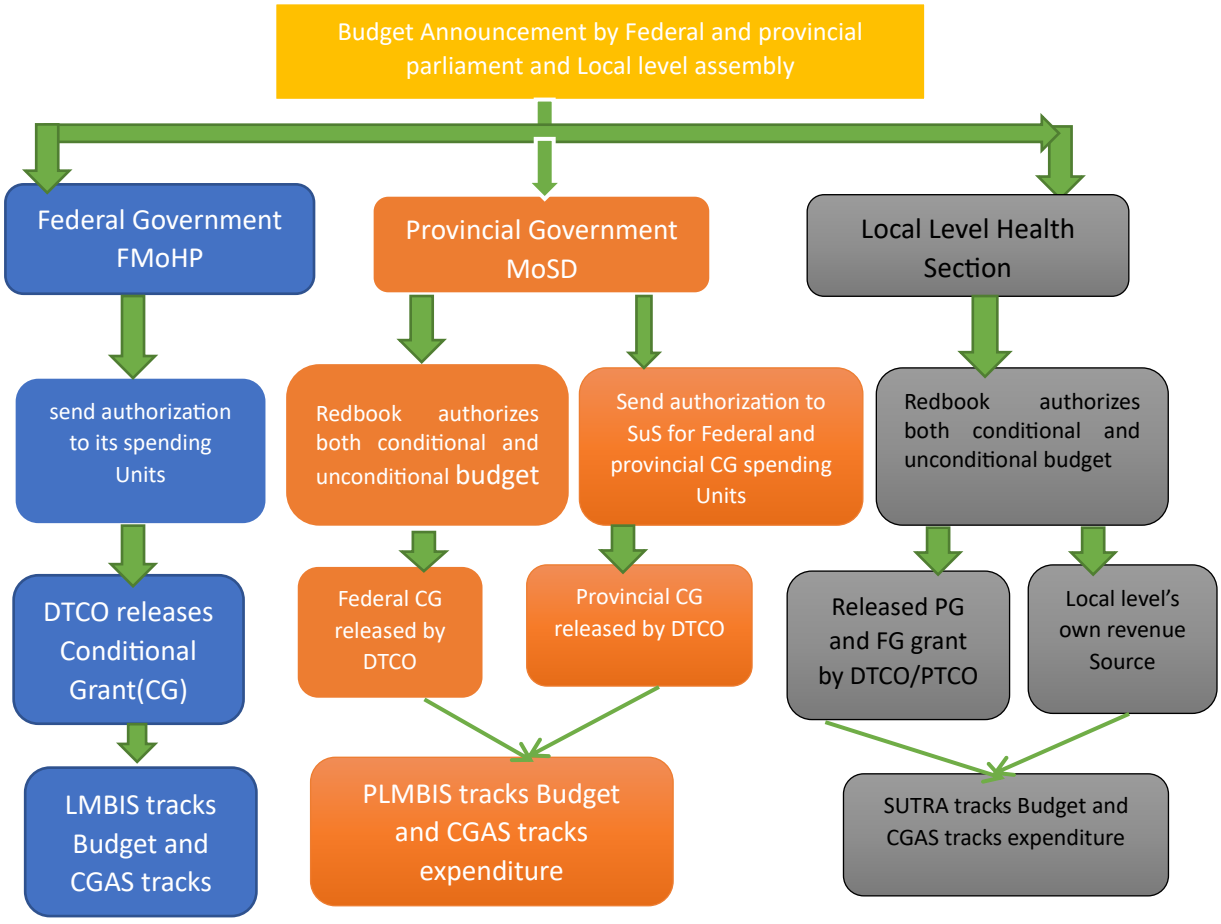
10. Budget & Finance

10.1. Vertical Coherence& Integration

Nepal's budget planning process begins in January each year with the National Natural Resources and Fiscal Commission (NNRFC) of the Government of Nepal defining the overall budget for the

country. The NNRFC is the constitutional body charged with the objective of ensuring the just and equitable distribution of natural and fiscal resources between all three spheres of government. The Ministry of Finance (MoF) then consolidates policies and programs from sectoral ministries, which is announced by the President of Nepal. Based on the decisions of the Resource Council/Committee, MoF provides budget ceilings and guidelines for sectoral ministries, and sends estimates of revenue transfer and equalization grants to PGs and LLs. The planning and budgeting process is completed in three phases, starting from the federal level and moving through the provincial and local levels.

Figure 3. The process of tracking of budget and expenditure



Source: *Health Sector Budget Analysis: First Five Years of Federalism, FMoHP*

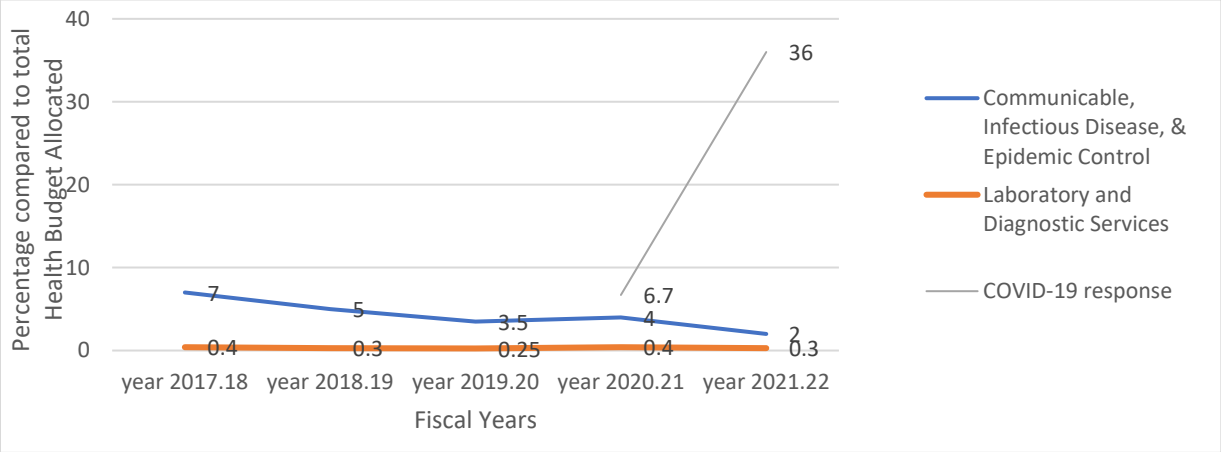
The data accessed from the "Health Sector Budget Analysis: First Five Years of Federalism" published by the Policy, Planning and Monitoring Division of the Federal Ministry of Health and Population gives the trend of coherence and integration in health sector budgeting in all three tiers of government. Some extracts of the report which includes selective analysis of the line items which are more linked with health emergency management are presented below.

Table 2. Percentage Allocation of Health Budget by Federal Government by selected Line Item/Economic Code (Amount in NPR millions)

economic code	year 2017.18		year 2018.19		year 2019.20		year 2020.21		year 2021.22	
	Budget	% of total budget	Budget	%	Budget	%	Budget	%	Budget	%
Total Budget	**46,866**		**56,420**		**68,779**		**90,690**		**133,121**	
Communicable, Infectious Disease, & Epidemic Control	3,225	7	2,703	5	2,418	3.5	3,705	4	2,957	2
Laboratory and Diagnostic Services	207	0.4	150	0.3	173	0.25	366	0.4	348	0.3
COVID-19 response	0	0	0	0	0	0	6,113	6.7	48,116	36

The trend analysis of the data presented above can be seen as follows.

Chart 3. Percentage Allocation of Health Budget by Federal Government by selected Line Item/Economic Code (Amount in NPR millions)



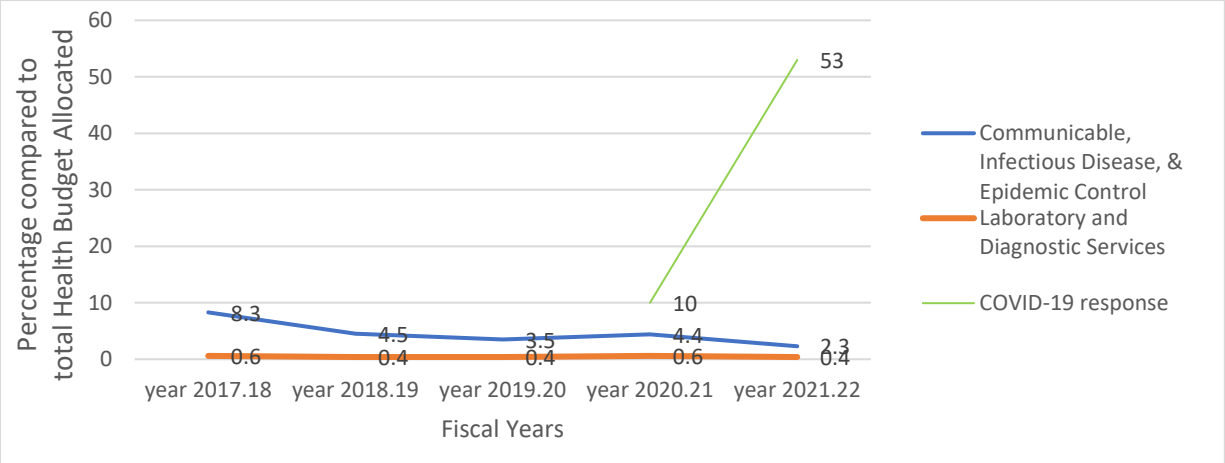
The above graph shows that allocation of budget for communicable, infectious disease & epidemic control has been following decreasing trend which is a warning sign. This shows that the government is not giving priority to the line item which is directly related to the public health emergency as well as resilient public health system.

Table 3. Percentage Allocation of Health Budget at Federal Level in selected Line Item/Economic Code (Amount in NPR millions)

economic code	year 2017.18		year 2018.19		year 2019.20		year 2020.21		year 2021.22	
	Budget	%	Budget	%	Budget	%	Budget	%	Budget	%
Total Budget	**37,024**		**36,673**		**41,268**		**59,855**		**89,190**	
Communicable, Infectious Disease, & Epidemic Control	3,064	8.3	1,649	4.5	1,451	3.5	2,631	4.4	2,011	2.3
Laboratory and Diagnostic Services	207	0.6	149	0.4	173	0.4	366	0.6	324	0.4
COVID-19 response	0	0	0	0	0	0	6,052	10	47,250	53

The above table is further emphasized by the graph below.

Chart4. Percentage Allocation of Health Budget at Federal Level in selected Line Item/Economic Code (Amount in NPR millions)



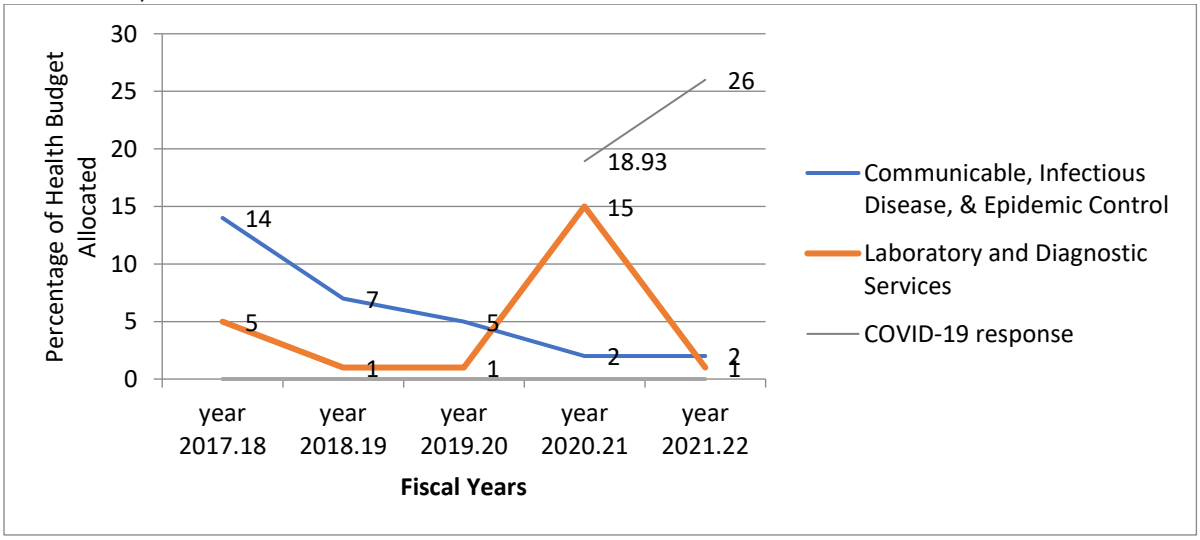
From the chart it is observed that the budget in the line item related to preparedness for the public health emergency is following the decreasing trend at federal level.
Now, while we move towards the sub national level, the data from the same report is presented below.

Table 4. Percentage Allocation of Health Budget at Provincial Level by Line Item/Economic Code (Amount in NPR millions)

economic code	year 2017.18		year 2018.19		year 2019.20		year 2020.21		year 2021.22	
	Budget	%	Budget	%	Budget	%	Budget	%	Budget	%
Communicable, Infectious Disease, & Epidemic Control	13	14	654	7	869	5	498	2	649	2
Laboratory and Diagnostic Services	5	5	114	1	136	1	3833	15	305	1
COVID-19 response	0	0	0	0	0	0	4976	18.93	7470	26

The Chart below depicts the trend presented by the above table.

Chart 5. Percentage Allocation of Health Budget at Provincial Level by Line Item/Economic Code (Amount in NPR millions)



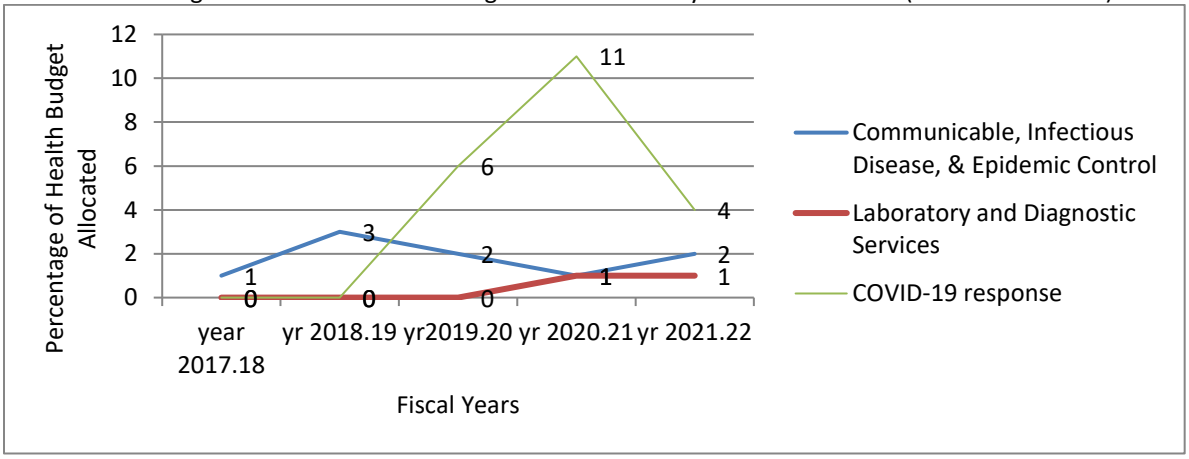
Source: *SuTRA FY 2017/18–FY 2018/19 for all provinces, PLMBIS FY 2019/20–FY 2021/22*

The above chart shows that in the last five years there had been decreasing trend of health financing by provinces in the communicable and infectious disease and epidemic control and the budget allocated in 2020.21 and 2021.22 for the COVID Response amounts to up to 26% of the total health budget. Hence preparedness aspect seems to be suffering due to this situation.

Table 5. Percentage Allocation of Health Budget at Local Level by Chart of Activities (Amount in NPR m)

economic code	year 2017.18		year 2018.19		year 2019.20		year 2020.21		year 2021.22	
	Budget	%	Budget	%	Budget	%	Budget	%	Budget	%
Communicable, Infectious Disease, & Epidemic Control	187	1	535	3	632	2	467	1	583	2
Laboratory and Diagnostic Services	6	0	61	0	143	0	261	1	341	1
COVID-19 response	0	0	0	0	1806	6	4015	11	1554	4

Chart 6. Percentage Allocation of Health Budget at Local Level by Chart of Activities (Amount in NPR m)



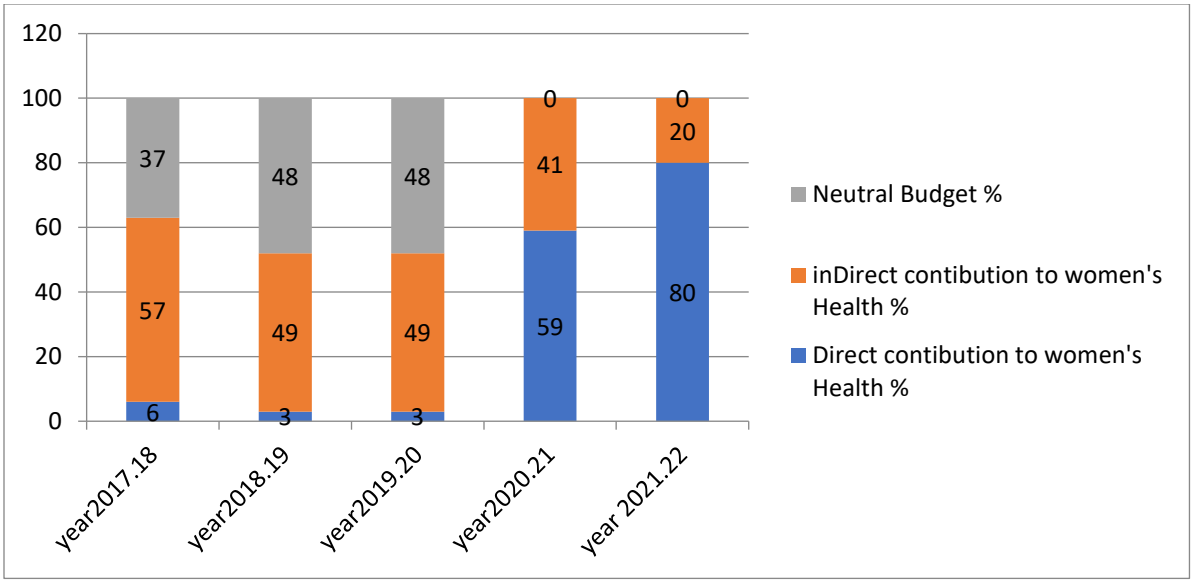
Note: the Local Level Disaster Management Fund, also includes a COVID-19 fund which is not included above

Source: *SuTRA FY 2017/18–FY 2018/19 for all provinces, PLMBIS FY 2019/20–FY 2021/22*

The scenario is almost similar to that of Provinces in the local levels, the financing for disease control, lab is very low. The budget of 2020.21 is largely attributed to COVID-Response. This trend shows that there is insufficient budgeting for forecasting, prevention, and preparing for public health risks. The spirit of federalism expects the local level to be robust enough to handle the public health risks by itself as far as possible. However, the budget allocation towards those areas seems meager.

Now, moving towards Leaving No one Behind, considering the gender (women) and economic status (poor) while preparing the budget by the Federal Government, the following was observed.

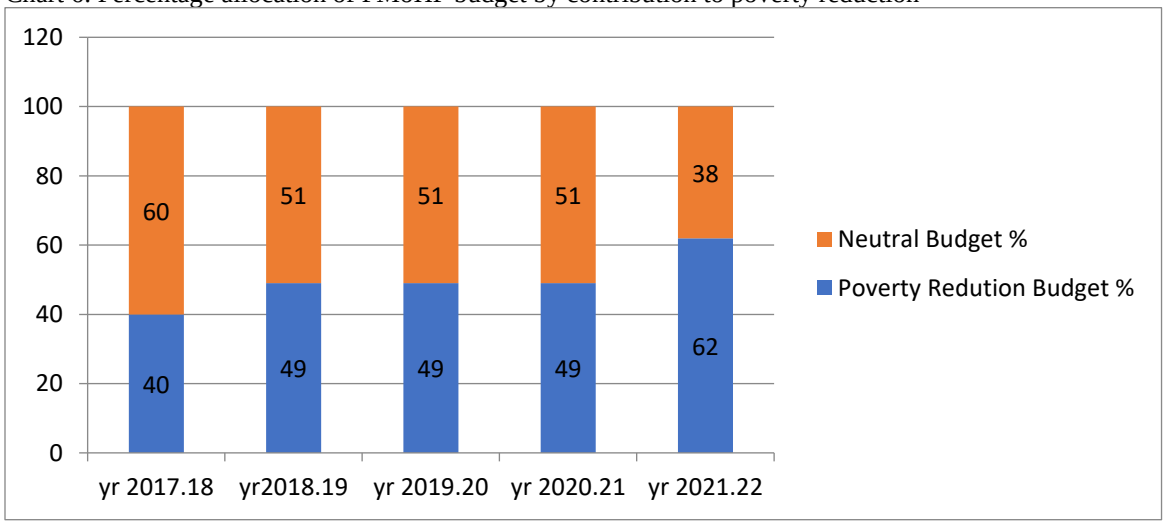
Chart 5. Percentage allocation of FMoHP's budget by contribution to women's health



Source: Health Sector Budget Analysis: First Five Years of Federalism

FMoHP classifies its activities according to the Red Book categories of directly or indirectly contributing to women's health and these are well incorporated into the e-AWPB. The largest proportion of the FMoHP budget is taken up by programmes indirectly contributing to women's health. This is because the budget is aimed at both men and women of all ages and those living in different geographies. FMoHP includes a budget for curative, disease control, prevention, and promotional services. The budget of the Family Welfare Division (FWD) and some others are considered programmes directly contributing to women's health. Since FY 2017/18, FMoHP's share of budget directly contributing to women declined sharply from 6.3% to 2.5% in FY 2019/20. This is mainly due to devolution of basic health services to LLs. The majority of basic health services include programme activities that directly contribute to women's health. In FY 2021/22, the neutral category was no longer valid and the share of budget directly contributing to women increased to 80%.

Chart 6. Percentage allocation of FMoHP budget by contribution to poverty reduction



Source: Health Sector Budget Analysis: First Five Years of Federalism(nhssp.org.np)

FMoHP refers to the Red Book to define activities contributing to reducing poverty. Figure above suggest that over the years, FMoHP's poverty reduction budget has increased from one third in FY 2016/17 to almost half in FY 2020/21. However, this just gives an indication and does not accurately define the proportion of the FMoHP's budget that contributes to reducing poverty.

10.2. Multi-sector engagement

At the Sub- National Government (SNG) level, provinces have been spending between 0.3% and 2.9% of GDP on health, which translates to NPR 384 to NPR 3,338 per capita spending in health in real terms. The health sector allocation against provincial budgets is between 5.8% and 10%. Over the years, the health budget has been increasing at the SNG level, and it is encouraging to observe that internal sources are emerging as an important source of funding. This is a positive message in terms of increasing the fiscal space for health. Federal conditional grants for LLs are also important. Most of the health budget is allocated under programme heading in PGs, and under salary and wages in LLs.

The concern of under and over allocation, including duplication, is the most cited challenge for health conditional grants. More importantly, it is time to discuss an exit plan for the conditional grant modality at the PG level as more than 60% of the health budget is financed through internal source. In the absence of proper policy guidance on health planning and budgeting at the SNG level, an opportunity to realize SDG targets could be missed.

The policies and program of federal, provincial and local governments are not sufficiently aligned with their budgets.

11. Monitoring & Evaluation

11.1. Vertical Coherence & Integration

Target 3.d not being a priority in terms of SDG goal is in almost neglected state. Only National Focal Point is responsible, provinces are made responsible through budgeting only.

The monitoring is to be done by National Planning Commission as prescribed by its framework.

At the apex level, a Steering Committee for Implementation and Monitoring of the SDGs has been established under the chairmanship of the Rt. Hon. Prime Minister.

The Committee provides policy directives, facilitates partnerships and oversees the financial, human and technical resources required for the implementation of SDGs. Below Steering Committee, there is SDG Implementation and Monitoring Committee. This is chaired by the Vice-chair of the NPC and provides guidance to the federal ministries, province and local levels for implementing and mainstreaming the SDGs in their plans and policies.

It is therefore imperative that the legislators in parliament remain at the forefront of the monitoring, and review regulatory processes that have a bearing on the achievement of the SDGs. To raise awareness with respect to the SDGs and promote oversight, a 14-member parliamentary committee on SDGs and governance has been constituted.

At provinces level there is no specific monitoring mechanism and even if some aspects of health are monitored at provincial and local level, they are not reported.

Meanwhile, the NPC has prepared model monitoring and evaluation guidelines for the provincial level.

A national strategy designed to address the issues of data collection, reliability and standardization of the statistical system has been formulated and implemented. A new Statistics Act has also been drafted and is under approval. NPC has prepared M&E guidelines for the monitoring and evaluation of provincial SDGs targets, which will track progress, identify problems and issues and help solve the problems of implementation as they arise.

The Central Bureau of Statistics (CBS) is the country's apex statistical agency for the collection, standardization, and quality assurance of data. The monitoring and evaluation of national projects and initiatives is a basic function of the National Planning Commission. The National Development Action Committee chaired by the Prime Minister addresses problems of coordination and project bottlenecks at the highest levels and has paid special attention to initiatives that influence the achievement of the SDGs.

Lack of data altogether or paucity of appropriately disaggregated relevant data or lack of up-to-date data impose limitations on SDGs tracking and monitoring. The 2021 population census data which is yet to be published is expected to be closely aligned with the SDGs and address specific issues related to SDGs data generation, disaggregation, and existing data gaps. Meanwhile, NPC has been using CBS-generated data resulting from the different planned and proposed periodic surveys to address SDGs data gaps. However, due to a lack of alignment in surveys conducted, there is a difference in data (due to being conducted at different timeframes) on which to base the indicators on.

Chapter 4 – Conclusion and Recommendation

12. Conclusion:

Nepal is among those countries whose IHR compliance has not been assessed by an external party after 2015. Joint External Evaluation (JEE) to be conducted as a key component of the IHR's Monitoring and Evaluation Framework, is in the pipeline. The only mechanism that is active is the State Party Self-Assessment Annual Reporting (SPAR). Nepal has been reporting timely in the web portal e-SPAR. However, the baseline figure 77 is based on the WHO Assessment, 2015 and due to lack of data, NPC, in its progress report for 2016-2019 could not include any data regarding SDG Target 3. d. Taking the scores shown by e-SPAR as a reference, Nepal does not seem to be able to meet the milestones set and ultimately the target for 2030. Hence, it is time that the NPC takes steps to revise the milestones and the target defined for SDG target 3.d to make them more realistic.

In terms of policies, there seem to be more than sufficient policies at the central level. However, there is still no specific policy, strategies or guidelines specifically linked to forecasting, prevention and preparing for the public health risks developed totally in the initiation of the provinces themselves. Further, not all provinces have developed specific strategies to address the needs of unreached population. The policy alignment with sub national governments is the issue of this time.

Regarding the institutional arrangements, there are well set permanent structures to work for emergency situations. Institutions working towards Disaster Reduction and Management seem to be present at all the levels of the government. Yet, coherence and coordination between the governments as well as the different institutions under the same government is missing. Hence though present, the institutions don't seem to be functional. During COVID and other emergencies temporary structures were added, which increased the number of the agencies, which led to difficulty in the jurisdiction of work and coordination.

The only measure that seems to be appealing to the sub national governments to be aligned to the national priority is the financial one i.e., Budget. However, even that doesn't seem to be sufficiently allocated in terms of public health emergency. It follows firefighting approach and lacks preparedness and proactiveness which are the major measures to contain any public health emergency and remain resilient.

Also, the analysis of coherence and integration, LNOB and Multi-sectoral involvement in the Monitoring, evaluation and reporting framework shows that there is still a long way to go.

The need of coherence in The SDGs which came just after the adoption of federalism by the country seem to have suffered due to the politically transitional phase of the country. Six years have already passed and the nation is still in the phase of transition where the activities like institutional development, and human resource management are yet to be done. The progress till now is still based on the framework that were existing before federalism. Hence the remaining 8 years till 2030 seem to bear the burden of this lagging behind. And further, COVID-19 has added much stress to the public health system of a developing country like Nepal.

13. Recommendation:

Being a member of WHO and a state party to the IHR, Nepal is liable to capacity development, regular assessment of core capacities, and emergency preparedness as prescribed by the IHR. The capacity score is directly linked with SDG target 3.d. indicator 3.d.1. Not just to meet the SDG commitments but also to adhere to the very spirit of the constitution, the Government of Nepal along with all the sub-national and the local governments and the other sectors including private sectors need to work in proper coordination to fight the challenges of national as well as the global Public Health risks. This is possible only through the joint efforts and coordination of the federal, provincial, and local Governments in the areas of budget and resource management, border surveillance, diseases testing, quarantine, isolation center management, relief, and vaccination services. In this regard, the assessment of the laws, policies, institutional arrangements, planning and financing systems, and monitoring, evaluating and reporting mechanisms and practices related to the forecasting, prevention, and preparedness towards public health risks in Nepal, the following seems to be improved in future.

1. Disaster Management Code should be formulated by integrating the provisions of various laws related to disaster management such as the Infectious Diseases Act, Public Health Services Act, Disaster Risk Reduction and Management Act, Local Government Operation Act etc. It should demarcate the jurisdiction of the federal, provincial, and local levels.
2. All entities related to disaster management should be integrated and a single entity should be set up and devolved to the federal Provincial and local levels. Such institutions need to be institutionally strengthened with the necessary tools. A mechanism to regulate and direct overall disaster management should also be set up.
3. Proper attention should be directed toward research and analysis activities.
4. A permanent information repository should be established so as to enhance content related to forecasting, and prevention of public health risk in the means of communication that inform the public and increase public awareness.
5. The risk communication channel which is present should be made proactive.
6. In order to make vaccine procurement effective, the procurement process should be made effective by coordinating with the Heads of Government and manufacturers of other countries. Free vaccinations should be provided as soon as possible on a priority basis to cover people of all ages.
7. Various government and private hospitals should monitor compliance with health standards issued by the World Health Organization. While matching the service delivery standard and fees, private hospitals should consider the dire condition in the emergency and should encourage providing accessible and convenient services.
8. The capacity of the National Laboratory should be enhanced and a well-equipped laboratory should be established at the provincial level.
9. In order to conduct procurement in special situations including pandemics, crises, emergencies, natural calamities, and disasters, and in order to construct necessary infrastructure, procure materials and consultancy services for conducting rescue and relief operations on the basis of the emergency decision, separate procurement procedures should be enacted.
10. A policy should be formulated after adequate study and analysis and should be implemented so that there is coherence between all levels of government in emergency situations.

11. Health workers as well as others serving on the front line should be kept safe and personal safety items should be made easily available to those working on the front line and an environment should be created to work with motivation.
12. The government of Nepal should seek to shift to the Health in All Policies (HiAP) Approach as health is the most important asset of Human Development.
13. The participation of local people's representatives and political parties, along with CSOs and private sectors should be enhanced and adequate orientation and training should be provided. The security personnel and immigration sector personnel working to contain the situations like epidemics and pandemics need to be motivated well and equipped well with the trainings.

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