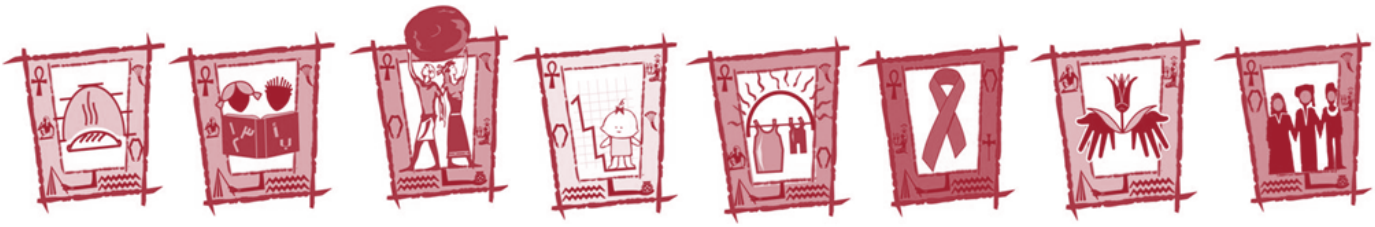
2010

Monitoring MDGs Progress

Health sector and beyond

This is a process report of one-day interaction programme, organised jointly by the Ministry of Health and Population and Association of INGOs Nepal – Health Working Group on February 10, 2010 in Hotel Malla, Kathmandu.

Sudip Pokhrel
Programme Facilitator



ain

Monitoring MDGs: Health sector and beyond

Interaction Programme – February 10, 2010, Kathmandu

Context

Nepal made significant progress on reducing the child and maternal mortality ratio as compared to its baseline (1990); however significant efforts are still needed for further reduction of mortality. Though mortality rate is reduced, the morbidity pattern is still high for certain diseases. Similarly, Nepal still faces challenges to break the transmission cycle of HIV/AIDS, reduce the occurrences of malaria, diarrhoea & other diseases. In order to achieve the health Millennium Development Goals (MDGs) within defined timeframe, review of its progress is imperative to gauge the progress made so far, further enhance performance, and identify co-factors associated with health impacts.

MDG progress review is also necessary to explore linkages with non-health MDGs with health MDGs, identify social determinants related to health outcomes, and illustrate investments from other sectors towards health MDGs. The timing of the review is also pertinent given that the Nepal Health Sector Plan (2010-2015) is being developed and insight gained from the MDGs progress review will contribute in elaborating health interventions for the next five years.

Objectives

Ministry of Health and Population (MoHP) and Association of INGOs (AIN), Health Working Group Nepal jointly organised the interaction programme with the objectives to:

- Review the current status of health MDGs ;
- identify the association and attributable contribution of non-health related MDGs for the achievement of health MDGs;
- identify barriers, if any, that limit the achievements of health MDGs on time;
- and propose specific health and non-health measures and recommendations to improve the current health progress for timely achievements of the health MDGs

Participants

More than 60 invitees representing MoHP and its subordinate authorities, AIN members, health sector external development partners (EDPs), and NGOs participated in the programme. *A list of participants is included as annex-IV.*

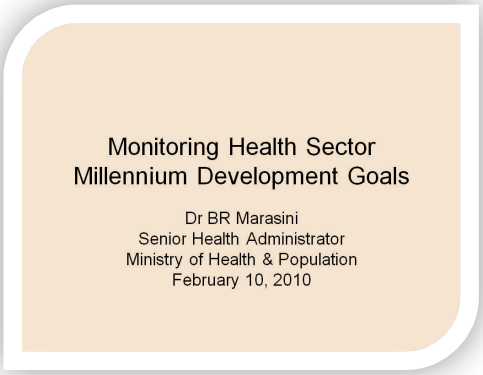
Proceeding

Programme agenda is included as annex-I. The interaction programme was inaugurated by the chief guest Hon. vice chairperson of the National Planning Commission (NPC) Dr. Yuvaraj Khatiwada. Acting Health Secretary and chief of

Policy, Planning, and International Cooperation Division (PPICD) of MoHP Dr. Laxmi Raj Pathak chaired the morning session and Hon. member of the NPC Dr. Chet Raj Pant chaired the afternoon session of the programme. Dr. Baburam Marasini, Senior Health Administrator of MoHP welcomed the participants and Mr. Om Pd. Gautam coordinator - AIN Health Working Group highlighted the day's objectives.

Presentations

This section provides synopsis of the presentations made on the day. *Complete set of presentations is included as annex-II.*



Monitoring Health Sector MDGs

At the outset, Dr. Baburam Marasini presented the current status of health related MDGs in Nepal. In his presentation, Dr. Marasini highlighted the health outcomes and health sector progress towards achieving MDG one, two, and three. In his subsequent presentation on the health MDGs, he highlighted the current status and progress as well as cross cutting factors like introduction of Sector Wide Approach (SWAp) that has influenced the progress towards health MDGs. After delving into some challenges to be addressed, he wrapped up his presentation with the concluding thought that Nepal is in track of achieving most of the health MDGs (goal 4 and 5) except HIV and AIDS where present efforts require additional boost to be on track.

MDG Indicators	Goal Achievement by 2015	Risk
MDG—1 (Malnutrition)	Possible	Climate change
MDG—4 (Child mortality rate)	Near MDG goal	Neonatal health
MDG—5 (Maternal mortality ratio)	Possible	Access and equity
MDG—6 (Tuberculosis)	Near MDG goal	HIV
MDG—6 (Malaria)	Near MDG goal	HIV
MDG—6 (HIV)	Difficult	Labour migrants

Table 1: Status of Health Sector MDGs in Nepal

Following Dr. Marasini's presentation, members of a panel setup to further the discussion delivered their remarks on Nepal's progress on health MDGs. Some pertinent remarks were:

MS. DALE DAVIS – VICE CHAIR, AIN

- Multi-sectoral collaboration is needed for achieving health MDGs – strong partnership between state and non-state actors, mapping of their efforts, and developing concerted multi-sector approach should be high on the agenda
- Role of INGOs, with their engagement in diverse sectors and wider reach in almost all districts, is vital for the progress in achieving MDGs
- In 2006, INGOs have spent NRs. 4 billion towards the progress of MDGs. Now that we only have five more years to achieve the goals, more efforts are needed specially when it comes to focusing on poor and marginalised.
- AIN is committed to work with the government, its external development partners, and the NGOs for the next five years to help Nepal achieve the MDGs

MR. IAN MCFARLANE – CO CHAIR, EDPS

- Data validity remains an important question. Data quality requires further improvement.
- We should work on ensuring sustainability of efforts – good practices of both state and non-state actors need to be build upon
- Improved inter-sectoral approach is required to strengthen health system and improve service delivery
- Population is not getting the attention it should; this is an extremely important area and more programmatic focus should be accorded

DR. JAGADISH C. POKHAREL – EX VICE CHAIR, NPC

- This event and the MoHP-AIN MDGs monitoring effort comes at opportune time as the government is in process of writing the next three year development plans
- Two frequently raised issues need focus: quality of nationally collected data and resource constraints to implement innovative approaches

HON. DR. CHET RAJ PANT – MEMBER, NPC

- Government plans should reflect the available resources; it should only promise what it can deliver
- National plans should be demand based; for example, micro-credit and school health programme should be expanded further
- MoHP should increase its collaboration with other social sectors

HON. DR. YUVARAJ KHATIWADA – VICE CHAIR, NPC

- This joint effort of MoHP and AIN to review the health MDGs is pertinent as it can provide insight into the periodic plans
- Inter-sectoral planning and integrated planning requires more emphasis; I suggest that MoHP form thematic groups to strengthen inter-ministerial coordination
- Effective coordination among different actors at the local level is still not up to the mark; it needs improvement
- We should be cautioned about aggregate achievement in poverty reduction and MDGs not diluting focused intervention for certain marginalised groups who remain outside of the mainstream development process
- Producing results vis-á-vis the inputs imparted , improving data quality, and coordinating activities outside the purview of SWAp remain challenges to be addressed for achieving the MDGs
- Our development partners shouldn't be fretful about new initiatives the government is likely to introduce in coming days
- The government expects the development partners to contribute more money in infrastructure projects like road construction
- The government also expects that development partners minimise their operating costs and not compete for resources

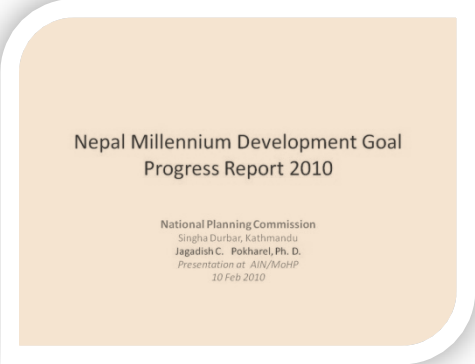
DR. LAXMI RAJ PATHAK – ACT. SECRETARY, MOHP (SESSION CHAIR)

- The next phase of Nepal Health Sector Programme (NHSP II) focuses on health system strengthening and improving access to services; this MoHP-AIN collaborative MDG review process will provide insight for NHSP II

- Improving infrastructure and logistics, localising the MDGs, reviewing of cost-sharing strategy, and increasing inputs from current US$ 3.5 per person to US$ 12 per person of GDP are some of the forthcoming approaches for Nepal's health sector
- Even though overall access to services has improved over the years, among certain population groups, it remains poor. We need to design specific focused interventions to reach and cater to these groups
- Managing human resource remains a challenge; especially placing right person in right place will improve implementation of programmes

Presentations on Current Status of Non-health MDGs, Gaps and Challenges

The afternoon session, chaired by Hon. Dr. Chet Raj Pant, started with presentations on non-health MDGs and other determinants of health outcomes. Only three presentations, out of expected seven, were made on the day.



MDG1: Poverty and hunger

Dr. Jagadish C. Pokharel focused on MDG1 as part of the overall Nepal MDG Progress Report 2010 which is still in the making.

Dr. Pokhrel said some debate on food security vs. nutrition is going on and perhaps food security may be prioritised higher, specially reducing food dependencies. He said, elucidating findings of the Progress Report 2010 so far, that the overall poverty is reduced and poverty gap narrowed but ensuring equity, justice and equal distribution still remain issues to be tackled. Furthermore, disaggregation of data is something to be improved. He summed up his presentation with the notion that poverty goal is likely to be achieved but not without some caveats.

MDG7 (Target 10): Water and sanitation

Mr. Suman Sharma, joint secretary of Ministry of Physical Planning and Works (MPPW), presented the status of target 10 (water and sanitation) of MDG7.

At the onset, Mr. Sharma juxtaposed two major targets Nepal is pursuing in the water supply and sanitation sector, i.e. the MDG goal of halving the population without access to safe water and sanitation by 2015 and the national target of achieving universal access to basic water and sanitation by 2017. He said Nepal is well on track to meet the MDG target but additional performance is required to meet the national target of universal access. He said strong community driven approaches, government's commitment to achieve universal access by 2017, good state and non-state partnership and the choice of technically viable small schemes at community level has worked for the sector; whereas weak sector alignment, low functional status of

services, insufficiency of resources, and rapid urbanisation are some of the barriers that need to be addressed in future.

In conclusion he stressed on strong linkages required with the health and education sector and suggested few areas of collaboration like knowledge and resource management, awareness creation, water quality surveillance monitoring, and developing information base.

Other contributing development work: Trail bridges

Mr. Mani Ram Gelal, Project Manager of Suspension Bridge Division of Department of Local Infrastructure Development and Agricultural Roads (DoLIDAR), presented the overview of trail bridges in Nepal as a contributing factor in achieving the MDGs by facilitating access to services.

In this presentation Mr. Gelal walked through the historical development in construction of trail bridges in Nepal, highlighted current achievements and future strategy of the division. His presentation also showcased a pictorial on different types of trail bridges installed in Nepal.

Floor Discussion

Following the presentations, floor discussion with the presenters and the participants ensued. *Questions and comments penned down by the participants during the presentations are included as annex-III.* Following matrix highlights some questions and responses:

Questions	Responses
Could you provide some insight on how poverty reduction was made possible?	The present findings are based on Labour Force Survey, which the Central Bureau of Statistics (CBS) considers comparable to national data. The facilitating factors for small reduction in poverty are employment and remittances. But sustaining them at nationally and internationally at the time of global recession is a challenge; therefore, some of the achievements may slide in the future. *(Dr. Pokharel)*
Is the link between poverty and malnutrition analysed?	For now we are extrapolating; the next Nepal Living Standard Survey (NLSS), the National Census 2011 and NDHS will have to look at it and clarify the picture. *(Dr. Pokharel)*
As MOHP and NPC are in the process of developing future plans, the achievements and progress made on MDGs could mask the geographical variations. In this context, would you try to achieve national target or focus on equity?	The challenge is to address disparities and variations across geographical pockets. We have to disaggregate our targets both at the macro and micro levels. Strengthening local bodies and good governance are important. The government has to partner with other agencies who reach up to the local level. How to maintain development agenda high against the political agenda is also a question for next few years. State restructuring may also create

	further uncertainty for MDG progress. *(Dr. Pokharel)*
How can we scale-up school health programme and establish better coordination between Ministry of Education & Sports (MoES) and MoHP?	We have developed National School Health Strategy in 2006 based on the needs assessment of 2005. We have to accept that we're weak at inter-ministerial collaboration. MDGs could be an opportunity for improving it; also both MoHP and MoES have presence in every VDC of the country. As health workers are already burdened with other programmes, their involvement in school health may not be sustainable. We have to invite non-state actors and NGOs to bridge that gap.
How do health related INGOs report their contribution and how do they coordinate at the district level to ensure they complement government services and avoid duplication?	Until last year we had no dialogue on it. INGOs used to report only to Social Welfare Council (SWF). Now MoHP is trying to create some mechanism for INGOs to report to it. However we still have to address the coordination issue at the district level. We are also trying to develop a strategy to avoid duplication of programme activities and improve coordination at the regional level. From this year on, MoHP and AIN Health Working Group will be working more closely so we can expect better coordination with the INGOs *(Dr. Marasini)*
What is 2009 Tracking Survey? Is it representative for Nepal?	It was a small survey done to validate Nepal Demographic and Health Survey (NDHS) 2006 findings, in particular to examine whether the Maternal Mortality Ratio (MMR) had reduced at a level shown in NDHS 2006. Moreover, it looked at the causes of MMR and found that haemorrhage, Eclampsia and suicide were the main causes of MMR in Nepal. MMR was found to be 219 against 281reported in NDHS. *(Dr. Marasini)*
What is a valid Contraceptive Prevalence Rate (CPR) figure?	Current CPR is 49.6% but if we combine urban data it goes up. Our target is 67% and unmet need is 25% *(Dr. Marasini)*
Why is mental health not part of MDG? Why a separate department for mental health not established in Nepal?	MDG is a global agenda. The UN Committee formed to address global problems did not include mental health. However, some countries have added supplementary goals to the MDGs, which Nepal can also do. Mental health will be an important component in the next five year health sector plan. *(Dr. Marasini)*
	MDG indicators can be added and adjusted so as to include issues such as climate change. For example, employment indicator was added to the MDGs after 2005. *(Dr. Pokharel)*
Has there been an evaluation of the impact of trail bridges?	We conduct post bridge building assessment in terms of population size benefitted and detouring time saved. Swiss Development Cooperation (SDC) has supported in compiling national data *(Mr. Gelal)*

Hon. Dr. Pant closed the floor discussion by thanking the participants for valuable discourse and expressed his commitment that the points and issues raised during the day would be considered by NPC when developing the next plans. He lauded the interaction programme saying it unearthed critical issues gave an insight on where things stand now. He thanked the organisers MoHP and AIN.

Closure

To end the proceedings for the day, Mr. Phanindra Adhikary, Steering Committee member of AIN, and Dr. Marasini thanked the presenters and participants for an insightful day. Both expressed their strong commitments, on behalf of MoHP and AIN, on working towards the achievement of the MDGs.

Facilitator's Observations

- The collaborative review of MDGs progress with MoHP underscored AIN's role of policy advocacy as well as supporting national systems
- Excellent turnout of the invitees, representative of different stakeholders, especially during the first half of the day
- Presentation on MDG goals two (education), three (gender and women empowerment), and eight (global partnerships) were not conducted; these would have further enriched the discourse and delved into crucial inter-sectoral linkages
- The on-going review of health MDGs is opportune as the government is beginning to develop the next three year plan (and MoHP is developing NHSP II). *Once the exercise to review the health MDGs is complete, a short dissemination event would be further beneficial*

Key, *recurring* issues of the day:

- Overall achievement in poverty reduction and MDGs shouldn't dissipate focus from certain groups that are yet to be benefitted
- Multi-sector collaboration and partnership between state and not-state actors are crucial for achieving MDGs
- Inter-ministerial coordination and coordination with other supporting partners, both at central as well as local level, needs to improve
- Quality of data (*and thus information*) remains poor and needs significant improvement

Annexure

Programme Agenda

Annex I

"Monitoring MDG Progress: Health Sector & Beyond"
Programme Agenda

Date: 10 February 2010 **Venue: Hotel Malla, Lainchowr Time: 9:30 -5:00**

Time	Activities	Responsible Org.	Responsible person
9:30-10:00	Registration and Tea	All	
10:00-10:10	Welcome remarks	MoHP	MoHP
10:10-10:15	Objectives of the workshop	AIN HWG	Mr. Om Pd. Gautam
10:15-10:20	Inauguration of the workshop	NPC	NPC Vice Chair
10:20-11:15	Presentation on current status of health MDGs, gaps and challenges: • *Child mortality* • *Maternal health* • *HIV/AIDS, malaria and other diseases*	MoHP	Dr. Baburam Marasini
11:15- 11:35 *3-5 Minutes each*	• *Remarks by AIN Vice Chairperson* • *Remarks by EDP* • *Remarks by Director General, DoHS* • *Remarks by NPC Member* • *Remarks by Chief Guest (NPC Vice Chair)* • *Concluding remarks*	AIN EDP DoHs/MoHP NPC NPC MoHP	Ms. Dale Davis TBD Dr. Y.V. Pradhan Dr. C.R. Pant NPC Vice Chair Chair of the session
11:35-11:45	*Tea break*		
11:45-1:00	Presentation on current status of non-health MDGs, gaps and challenges: • Eradicate extreme poverty and hunger • Achieve universal primary education • Promote gender equality and empower women • Ensure environmental sustainability • Develop a global partnership for development. • Other contributing development work *Note: Only 5-10 min presentation for each goal*	NPC, MoE MoWCSW MPPW MoF Dolidar, Road, Suspension Bridge	Former VC: Jagdish Chandra Pokhrel Lava Dev Awasti Ram P Aryal Suman Shrama Lal Mani or EDP Chair Respective org. representative
1:00-2:00	Lunch		
2:00-4:30pm	**Discussion**: Based on the meta card received from the participants. Discussion will be focused on: • Discussion on gap and challenges tabled by each presentator on each MDGs. • Identify key interventions to meet those challenges in relation to health MDGs.	MoHP/DoHS	Dr. B. R. Marasini / Sudip Pokharel
4:30-5:00pm	**Wrap up** **Vote of thanks**	Sudip Pokhrel Phanindra Adhikary MoHP	

Organized by: MoH&P ***Supported by: AIN Health Working Group***

Presentations

Annex II

Monitoring MDG Progress: Health Sector & Beyond

Welcome

Jointly Organized By:
MoHP and AIN Health Working Group

"Monitoring MDG Progress: Health Sector & Beyond"

Objectives of the workshop

Om Prasad Gautam
Coordinator, AIN-Health Working Group

General Objective

- To review and empirically explain the status of health MDGs and contribution of non-health MDGs for health outcomes.

Specific Objective

- Review the current status of health MDGs
- Identify the association and attributable contribution of non-health related MDGs for the achievements of health MDGs.
- To identify barriers, if any, that limits the achievements of health MDGs on time.
- To propose health and non-health specific measures / recommendations to improve the current health progress for timely achievements of the health MDGs

Thank you

Monitoring Health Sector Millennium Development Goals

Dr BR Marasini
Senior Health Administrator
Ministry of Health & Population
February 10, 2010

Health Outcomes and Progress Towards Health Sector MDGs-1

Indicators	1990	2001	2006	2009	2015
MDG-1: Nutritional stunting (height for age) %		57	48		30
MDG-4:Neonatal mortality rate/1000 live births	50	39	33	20	16
MDG-4: Infant mortality rate/1000 live births	108	79	48	41	34

Health Outcomes and Progress Towards Health Sector MDGs-2

Indicators	1990	2001	2006	2009	2015
MDG-4: Under five Child mortality rate/1000 live births	161.6	91	61	50	54
MDG-5: Maternal mortality ratio/100000 live births	515	539 (1996)	281	229	134
Total Fertility Rate	4.6	4.1	3.1	2.9	2.4

Health Outcomes and Progress Towards Health Sector MDGs-3

Indicators	1990	2001	2006	2009	2015
MDG-6: HIV prevalence in 15-49 year/100,000 population	-	290	550		Halt & reverse
MDG-6: Tuberculosis prevalence rate/ 100,000 population	460	310	280		Halt & reverse
MDG-6: Malaria prevalence rate/100,000 population at risk	196	52	25		Halt & reverse

Core Intermediate Health Indicators

Indicators	Current status	Target for 2015	Remarks
Contraceptive prevalence rate	49.6% (any) 45.1% (modern -2009)	67%	
Skilled Birth attendance rate	28-8% (2009)	60%	Institutional 24.4%
Immunization rate –DPT3	81% (HMIS-2008)	100%	
Knowledge on Prevention of HIV Infection (at least one method)	Female-58.3% Male- 81% (NDHS-2006)	Female-100% Male-100%	

Millennium Development Goals in Nepal: Needs Assessment-2005

- It has included some of the goals from the cross cutting areas of other goals such as primary education and gender and women empowerment
- Gaps identified in child health and maternal health
- Requires additional resources, scaling up of the program & monitoring system

Millennium Development Goals in Nepal: Needs Assessment-2005

- Gaps identified in child health – nutrition program, comprehensive school health service to teachers and students,
- Second dose of measles for malnutrition
- Training of health personnel in child health related activities
- Implementation of neonatal health care package
- Japanese encephalitis vaccination-fulfilled

Millennium Development Goals in Nepal: Needs Assessment-2005

- Gaps identified in maternal health –
- Issue of unmet need for FP services
- Expansion of the safe motherhood services
- Training of FCHV for reducing maternal mortality

MDG-4: Child Health-Focus on Community Based Interventions

- Immunization
- Integrated management of childhood illness
- Nutrition- breast feeding, Vitamin A, Zinc supplementation, albendazole tablet, iodine supplementation
- Growth monitoring & food supplement
- Essential neonatal care

MDG 5: Maternal Health-Health System Strengthening Approach

- Training of health workers- skilled birth attendants
- Improve service delivery- antenatal services, delivery services-institutional outlets increased with increase in caesarean section, blood banking, post natal services,
- Infrastructure development- building construction

MDG 5: Maternal Health- Health System Strengthening Approach

- Quality of care- introduction of appreciative inquiry & maternal death audit
- Incentive to health workers for institutional delivery
- Supply of essential drugs and equipments related to safe motherhood
- Availability of ambulance

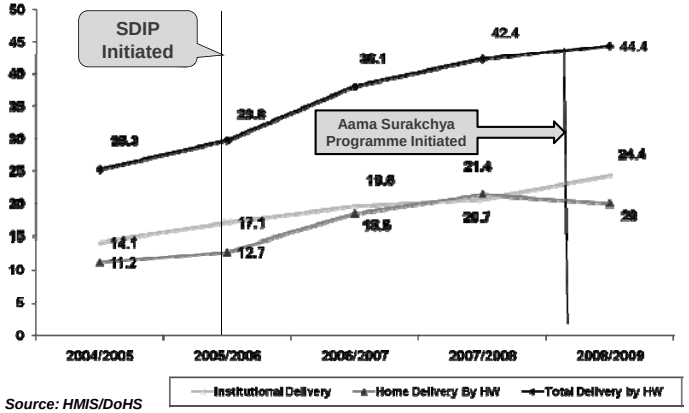
MDG 5: Maternal Health- Health System Strengthening Approach

- Increasing use of family planning services
- Safe abortion services
- Improve in nutrition during pregnancy
- Increase in safe motherhood related awareness in population
- Availability of ambulance services in all districts connected with road

MDG 5: Maternal Health- Demand Side Activities

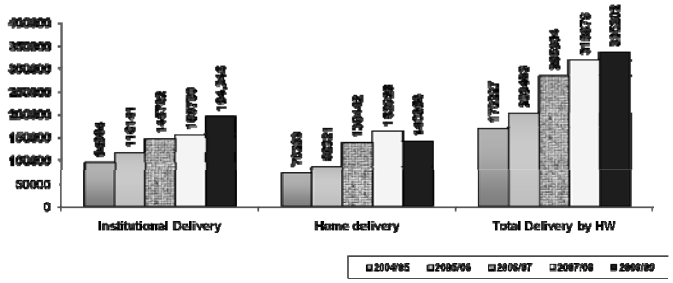
- Cash incentive for institutional delivery- Rs 1500 for high mountain districts, Rs 1000 for mountain districts and Rs 500 for terai districts
- Cash incentive Rs 400 for completing four antenatal visits, institutional delivery and two post natal visits
- Maternity waiting home- problematic pregnancy
- Female community health workers- increase awareness and demand at community level

Increasing Trend in deliveries conducted by health workers, based on Expected Births (fiscal years 2003/4 to 2007/8)

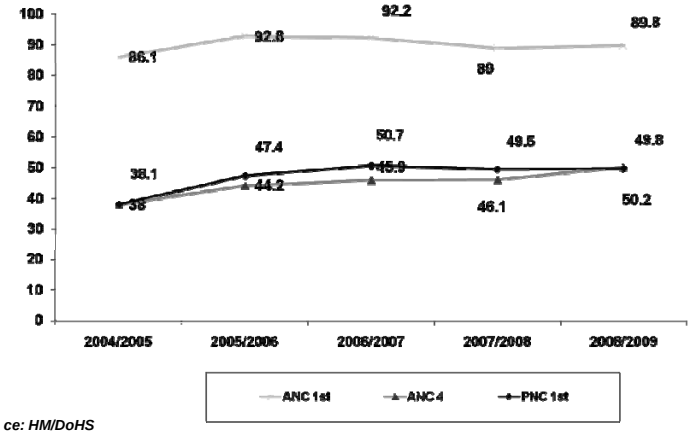


Source: HMIS/DoHS

NUMBER OF DELIVERIES (2004/05 TO 2008/09)



Trend in Percentage of ANC and PNC by health workers in fiscal years 2004/5 to 2008/9 based on expected birth (HMIS)



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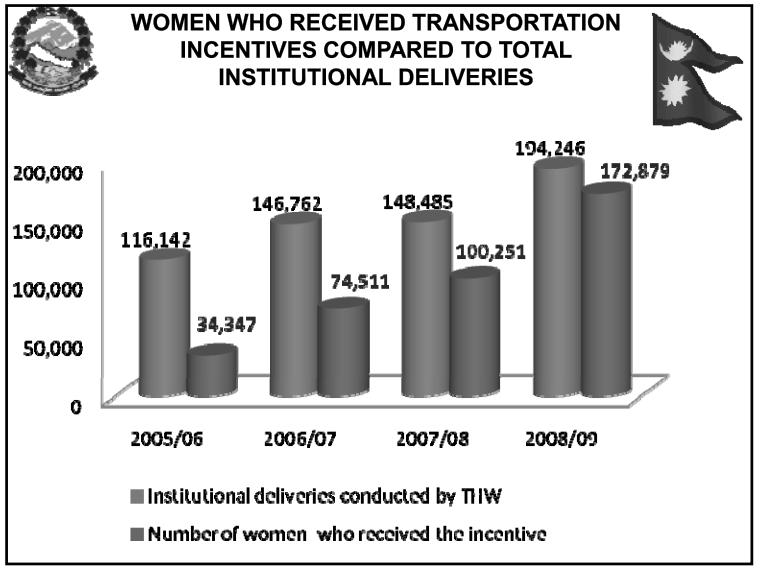


MDG 6: HIV and AIDS Status

- Prevention of Mother To Child Transmission
- Anti Retroviral Therapy
- Voluntary Counseling and Testing
- Education in general and behaviour change communication focusing high risk groups
- Condom promotion

MDG 6: Tuberculosis

- Directly observed treatment short course (DOTS)- even from sub-health posts and it is free
- Ensuring availability of anti- TB drugs
- Public- Private-Partnership approach in delivering services
- New treatment schemes for patients with HIV infection and multi-drug resistant tuberculosis

MDG 6: Malaria

- Long lasting pesticide impregnated bed nets (LLIN)
- Diagnosis and treatment of malaria cases
- Household spraying of insecticides in case of epidemic

Cross Cutting Factors

- Education –educated person has positive health outcomes
- Increase in roads- improves availability of food, utilization of services and use of ambulance during emergency
- Communication- availability of telephone in health facility, raising general awareness by media
- Increase in water supply and sanitation- less ill

Cross Cutting Factors

- Increasing women empowerment- especially through the female community health workers and mothers groups
- Cooperatives and micro-credit, community managed emergency funds and increasing income and role of remittance
- Increase in investment in health from GoN and introduction of sector wide approach (SWAP) in health

Pre & Post SWAP Health Sector Budget & Financial Performance

Description	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
Total health budget (in Billion NRs)	5.5	6.64	7.56	9.23	12.1	14.94
Share of budget (%)	4.93	5.86	5.95	6.41	7.16	6.33
Expenditure against allocation (%)	71.8	69.2	75.8	80.6	81.24	84.9

Progress on Health Sector MDGs

MDG Indicators	MDG Goal(2015) Achievement	Risk
MDG(1)-Malnutrition	Possible	Climate change
MDG(4)-Child Mortality Rate	Near MDG Goal	Neonate health
MDG(5)-Maternal Mortality Ratio	Possible	Access & equity
MDG(6)-Tuberculosis	Near MDG Goal	HIV risk
MDG(6)-Malaria	Near MDG Goal	HIV risk
MDG(6)-HIV/AIDS	Difficult	Labour migrants

Challenges -1

- Political stability
- Climate change- disease outbreak and decreased food production
- Neonatal health-
- HIV/AIDS especially labour migrants
- Deployment and retention of some core health professionals
- Rapid urbanization and migration to city areas- difficulty in accessing services

Challenges-2

- Infrastructure building in thinly populated districts
- Need to increase number of hospitals and hospital beds
- Increasing disparity in services especially in maternal health –rural vs. urban and poor vs. rich
- Progress monitoring is difficult

Conclusion

- Nepal is in right track for all health sector MDGs though achieving goal in HIV/AIDS is difficult provided the present efforts and priorities continue with positive development environment in the country
- Non-health sectors also contributed well in achieving the health sector MDGs

Thanking you for your kind attention

Nepal Millennium Development Goal Progress Report 2010

National Planning Commission
Singha Durbar, Kathmandu
Jagadish C. Pokharel, Ph. D.
Presentation at AIN/MoHP
10 Feb 2010

Agenda

- Describe briefly process followed so far by
  - Dr. Pokharel
- Team members describe
  - process/ method followed and data issue
  - Findings on
    - Status and
    - trend of indicator
  - Issues (data and substance related)
  - Suggestions to achieve the goal
  - Conclusion weather the goal is likely/unlikely to be achieved

Agenda contd….

- Presentation – Dr Pokharel
  - Summary of overall findings of all goals
  - Key issues
  - Major areas for focus
    - State building and consolidating, maintaining and accelerating the pace of achievements
    - Employment domestic and abroad
    - Inclusion and reduction of gaps
    - Climate change and adaptation issues
- Way forward to complete the report
  - Consultation with stakeholders
  - Reporting format

Sequence of Presentation

- Overview of process: Dr Pokharel
- Goal 2: Dr Pramod Bhatta
- Goal 6: Dr R. P. Shrestha
- Goal 3: Dr. Sushan Acharya
- Goal 4 & 5: Baburam Shrestha
- Goal 7: Dr Ram P. Chaudhary
- Goal 8: Dr Posh Raj Pandey
- Goal 1: Dr. Pokharel
- Summary : Dr Pokharel

Brief Overview of Process

- Meeting at NPC chaired by Dr. Puskar Bajracharaya
  - Presentation of approach and initial findings
  - Some members made more detailed presentation
  - Comments and suggestions
- Consultations of individual team members with respective Directors and officers
- Understanding about the method, data sources and data for analysis
- Consultations with UN Agencies
- Today's meeting expected to provide final input from NPC and suggest ways to solicit comments of other stakeholders– Ministries and Civil Society, Academia and experts

Slide

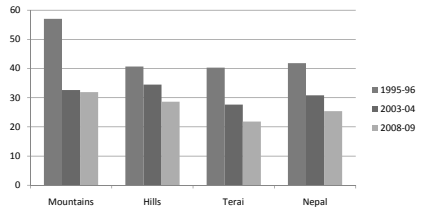
GOAL 1: ERADICATE EXTREME POVERTY AND HUNGER
Target 1.1
Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day

Indicator	1990	2000	2005	2010	2015 target
Percentage of population below $1 per day (ppp value)	33.54	NA	24.1	NA	17
Percentage of population below national poverty line	42	38	31	25	21
Poverty Gap	NA	11.75	7.55	6.10	--

Issues

- Methodological NLFS Report 2008 adjusted for consumption to compare with NLSS 2003/4 data--CBS
- Substantive issues
  - Trend is positive as the absolute poverty is reduced by almost 1% point every year
  - Gap also reduced from 7.5 to 6.1 which shows more people moving up and getting closer to poverty line
  - Caution–
    - Variation by ecological belt is visible – Terai has less poor than mountains and hills
    - Though there no new data to disaggregate by region, ethnicity and gender, the issues raised in the 2005 report still prevail.

Proportion of Poor by Ecological Belt



What have contributed to the poverty decline?

- Government strategies, plan and programs
- On average government allocated 43.7% of total annual budget on directly poverty reducing programs (past 5 years)
- Programs by NGOs/ INGOs
- Local level resource mobilization
- Macro policies and targeted redistributive policies
- Some social safety programs including identification of poor and increased budget on social programs

Issues

- Employment generation for sustainable income and poverty reduction
- 95% of poor live in rural areas and slower rate of poverty reduction in rural areas
- Mountains have higher poverty incidence
- Remittance major contributor to poverty reduction but rate of growth decline in remittance can become an issue

Recommendations

- 2005 Report's recommendations–
  - investment in labor intensive activities, infrastructure, skill training, wage based employment, credit for poor and special employment programs still valid.
- Global economic crisis and remittance is an issue which should be tackled immediately
- Agriculture should be modernized for making attractive to youth and returnee workers

Target 1.2

Achieve full and productive employment and decent work for all, including women and young people

Indicator	1990	1995	2000	2005	2010	2015
Proportion of employed people living below $1/ day	NA	34	NA	24	22%	17
Output per person employed constant 2005 purchasing power parity (US dollars)	505	647	790	969	1500	1920

Employment Population Ratio

- Employment to population ratio 81.7
  - Male 85.5
  - Female 78.5
- Average monthly earnings of paid employee (Rs) 5117
  - Male Rs. 5721
  - Female Rs. 3402
- Currently unemployed (In thousand) 253
  - Male 127
  - Female 126

Employment Status by Region/ Sector

Total Employed (in thousand) Male Female	11779 5519 6259	Himal	HIll	Terai	Urban	Rural
Fulltime paid employee (40 hrs and more) (%)	68	74.2	72.3	60.8	66.1	66.9
Part time (20-39 hrs) (%)	20	16.8	16.5	22.6	13.6	20.5
Part time (1-19 hrs) (%)	11	7.8	9.2	14.3	12.8	11.4

Observation

- The labor related indicators have remained relatively stable
- 30% of economically active pop. Underutilized
- 73.9% are engaged in agriculture
- Slight increase in women's employment in non-agriculture sector
- Children's employment decreased
- Girls participation rate of girls higher than boys especially between age group 10-14.

Issues

- Lack of investment for sustainable employment at the domestic sector
- Women's visible and non-visible works
- Safety, security, and protection of women workers
- Protection from exploitation
- Access to employment opportunities
- Access to labor justice
- Inadequacy of policy and government effective regulation of foreign employment and remittance (bonded foreign labor?)

Supportive Environment

- Labor and employment Policy 2062
- Foreign Employment Act 2064
- Bilateral agreements
- Welfare fund
- Pro-Women tax rebate and waivers

Recommendations

- Manage remittance to generate more employment
- State intervention to address the declining rate of remittance
- Agriculture technology
- Enhance access to employment opportunities for people in remote areas and weaker section of population
- Employment focus works
- Protect children and women from exploitation

Target 1.3

Halve, between 1990 and 2015, the proportion of people who suffer from hunger

Indicator	1990	1995	2000	2005	2010	2015 (target)
Proportion of undernourished population (percentage)	49	NA	47	39.9	22.5	25
International (India?) food price index consumer food price index		100		145.1	219.1	
Proportion of children under age five who are underweight (percentage)	57	47	53	45.2	38.6	29

Factors Contributing to Hunger and Their status

- Availability
  - Production of main crops vary; rice production declining and growth of other crops maize, wheat, barley is slow.
  - Production balance negative by 133,000 for the 2008-09 (june -july)
  - Regional variation in availability (40 districts food deficit between July 2008-July 2009);
  - Hills and mountains face net deficit with 14% and 19%
- Access
- Utilization

Hunger…

- Access
  - Price increase– price of rice critical
  - Market functioning
  - Especially in mountains with net food deficit
  - Access is social problem as well– girls, women, (24% women undernourished in Nepal, NDHS 2006). Much higher in Terai—33%

Supportive Environment

- Food as "human right" interim constitution
- TYIP "food security" special focus
- Increased budget allocation on Agriculture
- Revision of APP and strategizing the investment to address recurrent issues and
- New issues of climate change adaptation
- Subsidies in short term
- Transport network expansion
- Communication network helps avoid emergency

Recommendation

- Nutrition vs food security debate
- Increased emphasis on transport network expansion in remote areas
- Communication network expansion and use
- Continue with some food for work programs in remote areas but priority be given to "food for food" works. Reduce food depdency
- Appropriate and affordable technology research and expansion
- Better data base for informed decision making for emergency and chronic hunger elimination use and strengthen the one already existing information system

Summary of Findings on Overall Goal

- See attached overview matrix

Key Issues and Areas for Focus

- Mainly equity and redistribution and inclusion issue
- State restructuring/ building and consolidating the achievements so far and enhancing pace of positive gains
- Sustained employment generation
- Climate change and agriculture and consumption adaptation issue

Way Forward to Finalize Report

- Consultations with
- Government Agencies
- Donors
- Civil society, academia and others

Nepal is pursuing two major targets in the water supply and sanitation sector

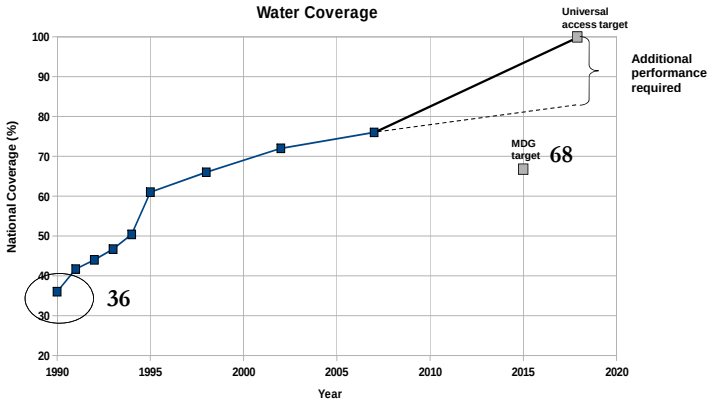
MDG 7 Target 10

National Target

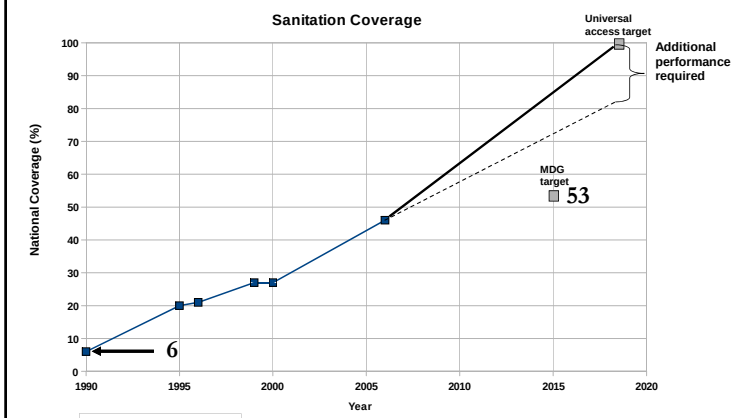
Where do we stand ?

Halve the population without access to safe water and sanitation by 2015

Provide universal access to basic water and sanitation by 2017



Source: MPPW



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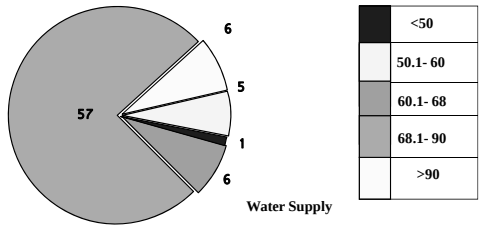
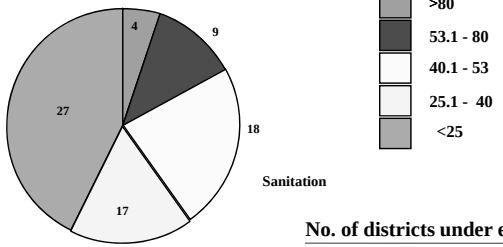
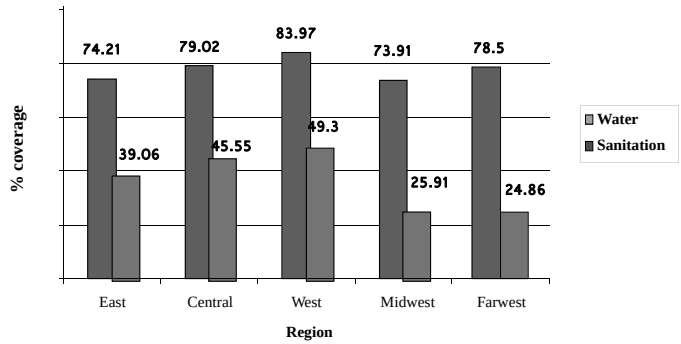
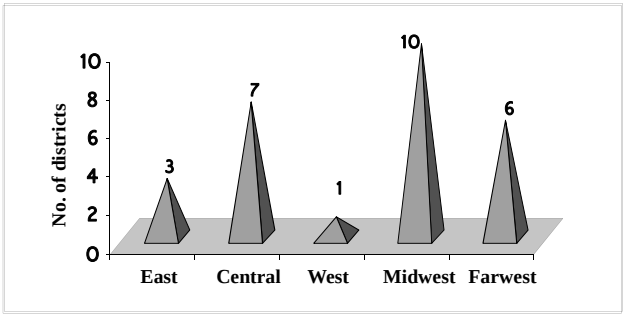




No. of districts under each coverage group



Regional Coverage on Water Supply and Sanitation



What has worked ??

- Strong community driven and demand based approaches in rural water supply – - intensive involvement of Users' Committees
- Cost sharing and community involvement in project implementation in small town areas
- Inclusive model of Water Users Committees, women and marginalized groups
- Involvement of CBOs and local NGOs in community facilitation
- School –led sanitation model, *sanitation for dignity approach*
- Choice of technically simple, small schemes manageable at community levels
- Partnership approach between government and non-government agencies (national committees in sanitation, water quality, rainwater harvesting, etc.
- Government commitment to achieve universal coverage by 2017

Main Barriers and Challenges in meeting the MDG

Sector alignment - fragmented implementation agencies and approaches leads to duplication in the sector – strengthened center and district based planning and monitoring

Functional Status - Weak monitoring and support system (Tenth plan estimated 56% systems required major repair or rehabilitation) - asset management . Sensitivity of coverage figures (JMP reports)

Resource gap - Annual gap of about US$ 23 million to meet MDG targets estimated (*source: Water Aid, 2004*)

Bridging the divide - Overcoming the geographical, social, cultural and economic barriers –how to reach the poorest of the poor ? **Remoteness**

Rural-Urban migration- Living up to the demand for services as a result of high urban growth (both conflict and opportunities)

Way forward

Strong sector alignment – coordination and synergy, MIS, SWAp, exchange and learning at national and regional levels, documentation establishment of SEIU provides a platform for knowledge management

Asset Management– Improving the effective functioning of services , redefining coverage

More resources– to achieve targets, equitable distribution for balanced growth

Enumerating and mapping of the poor and vulnerable – monitoring policy implementation, devising appropriate tools

Stronger focus on urban sanitation – Bad living conditions and severity or level of impact demands a stronger attention to

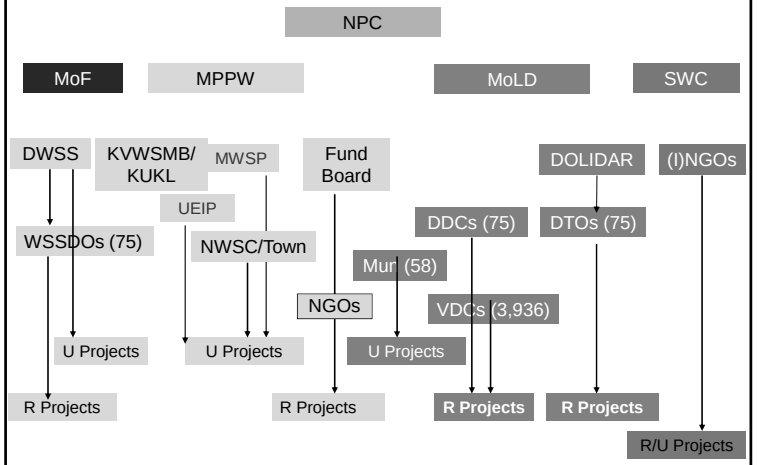
Capacity building and motivation– Capacity building of local bodies including community groups is a must; Motivation to service providers .

Inter-sector linkages – Linkage with health and education sectors .

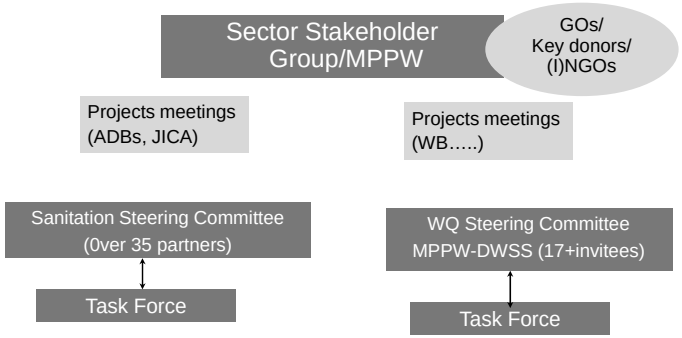
Areas of Collaboration

- Facilitation in Sector Coordination
- Knowledge management and exchange learning
- Capacity building at community and at service delivery levels
- Resource management – sharing of activities
- Awareness creation, program support, monitoring
- Impact studies and information base
- Improvement in service delivery, eg. water quality – Ministry of Health defined as the surveillance agency by National Drinking Water Quality Guidelines 2062

Institutional Arrangement



Coordination Arrangement

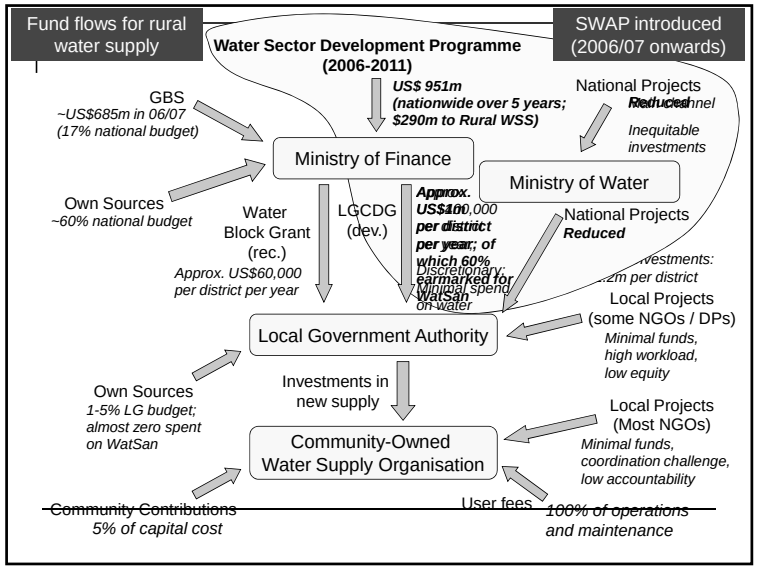


- ToR of SSG is being revised for improved coordination
- WQ/Sanitation committee have ToRs and membership but these all are loosely drawn and not fully accountable;
- Meetings are not very well organized and minutes are shared not regularly and action points not followed up

A Need for Catalyzing Change

- Why not learn from the past performance to improve future sector performance?
- Business as usual will not lead to achievement of national targets and service levels
- Key Issues require careful analysis and joint sector development programme
- Sector dialogue and investment coordination mechanism led by Government
- Need to shift focus from documenting additional coverage to functional (effective) coverage
- Service levels in relation to NWP and social economic development

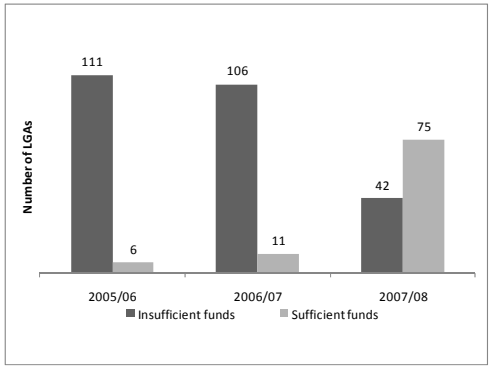
The Tanzanian Experience



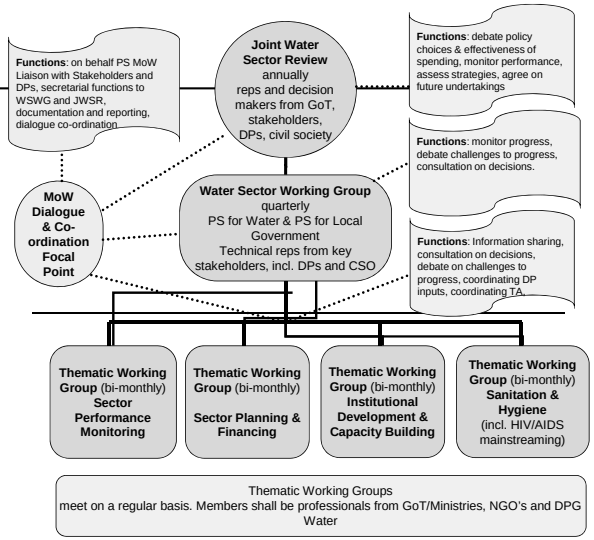
What works? WSDP's Strengths

- Increased volume
  - Total investment in the sector increased from ~5% to ~7% of the total national budget
  - Would meet investment requirements for MDGs if extended to 2015, and if efficiency is maintained
- Increased inter-district equity
  - Allocation formula to LGAs based on coverage
- Increased scope for accountability
  - On-budget, transparent system
- Increased predictability
- Use of the LGCDG system:
  - Working with existing procedures for planning, disbursement, financial management and reporting
  - Working towards increased discretion in the LGCDG

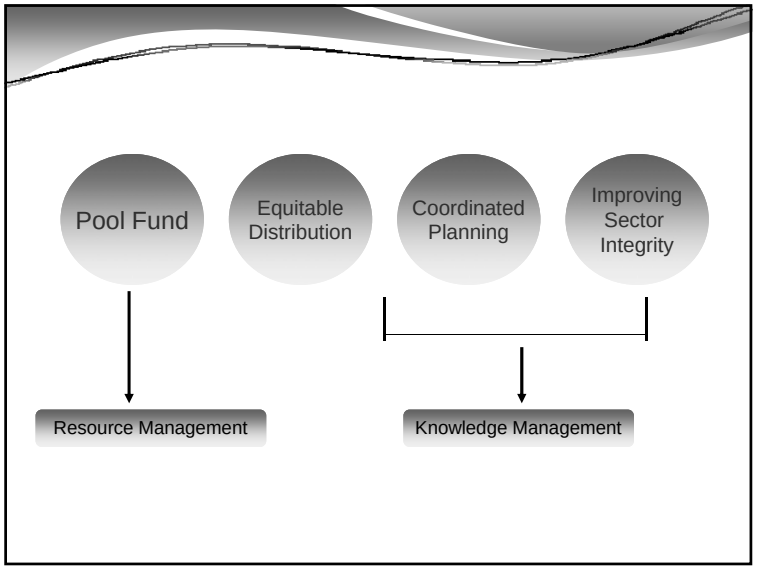
Number of LGAs with sufficient funds to meet MDG target in rural water supply has increased

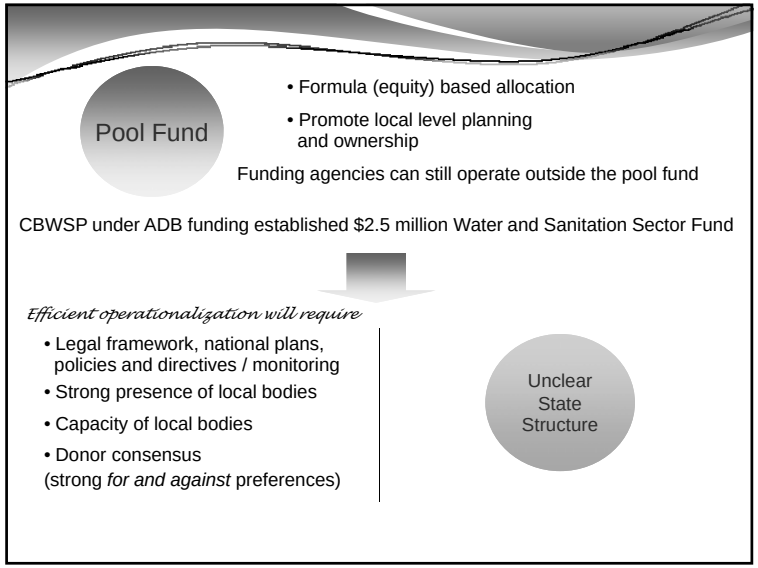


How does the proposed dialogue structure look like?



…… *In our case*


Pool Fund
Equitable Distribution
Coordinated Planning
Improving Sector Integrity
Resource Management
Knowledge Management


Pool Fund
• Formula (equity) based allocation
• Promote local level planning and ownership
Funding agencies can still operate outside the pool fund
CBWSP under ADB funding established $2.5 million Water and Sanitation Sector Fund
Efficient operationalization will require
• Legal framework, national plans, policies and directives / monitoring
• Strong presence of local bodies
• Capacity of local bodies
• Donor consensus
(strong for and against preferences)
Unclear State Structure


Moving towards SWAp
It is more than creating a pool of funds
A first wave of thinking for sector reform:
It is about ……
Coordinated planning, harmonization, coordination and monitoring
Enhancing sector efficiency, effectiveness and accountability
Let us start with knowledge management

Why ?

- global realization that increase in investment alone is not achieving intended service delivery

  Change how we work – efficiency and effectiveness
- we are hardly monitoring, documenting and disseminating outcomes and impacts

  Must define targets, indicators of service levels, consumer satisfaction and initiate monitoring in this respect, document and disseminate what works and what doesn't
- monitoring preference over-arches on implementation performance and activities

  Negligible or no monitoring for asset management and asset performance
- lack of integration of data

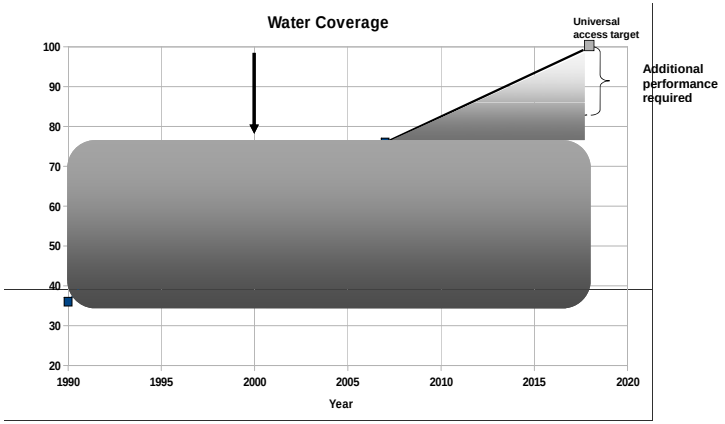
⇒ little integrity of information = poor linkage at national and international levels

- no common platform for monitoring – no preset common indicators !!
- not effective at inter –agency and therefore at the sectoral level
- no **Joint Sector Annual Reports**

  no claim and review of sector achievement and problems until it is too late
- unsystematic coordination – unstructured/ irregular meetings – little outcomes

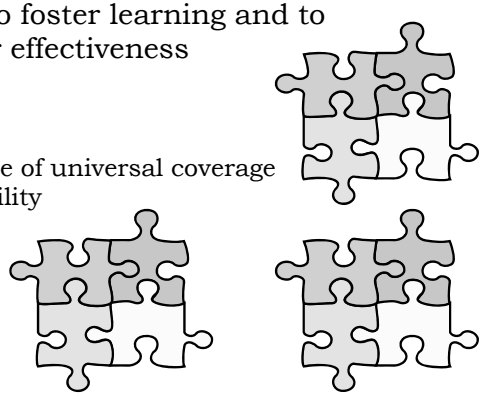
Need to set up a single dialogue mechanism for sector coordination

- A holistic picture needs to be painted for display
- refinement and integration of policies, sector directives and guidelines based on real time observations – legal framework
- *Systematic stocktaking and analytical review of assets – both in terms of physical facilities and service levels - is necessary to consolidate the benefits from investments made so far.*



A structured knowledge management process is imperative to achieve sector coordination, to foster learning and to enhance sector effectiveness

To solve the puzzle of universal coverage and its sustainability



Data integration and sharing

- operationalize and harmonize data collection, storage and dissemination
- creating a platform to collect, collate, disseminate and update data management
- linking with international monitoring platforms- eg. JMP

Improving sector accountability and performance

- data anlaysis and publication **- data integrity**
- publication of annual sector performance report
- **joint sector review –** strengthens sector performance through active civil society/ media participation
- publication of comparative achievements against pre-defined common set of indicators creates intra – sector competitiveness

Promoting learning and networking

- annual performance reports enable documentation of good practices
- joint sector reviews allow stakeholder feed back
- networking of agencies allows idea sharing / encourages collective problem solving / greater sector ownership
- early detection and diagnosis of emerging concerns
- establishing and nurturing common platforms for capacity building eg. sharing standards and methods, training of staff and users

Harmonizing Approaches

- Minimize confusions, agency bias and work towards more harmonized approach in policy, program and activities – synergy in efforts entails systematic and continuous observation, analyses, fine-tuning and modifications as necessary in policies, strategies and programs, legal frameworks. Harmonization also in standards and approach.
- Synchronize planning through annual workshops between major agencies to avoid duplication in programs

Promotes inter- agency tolerance, respect and learning ~

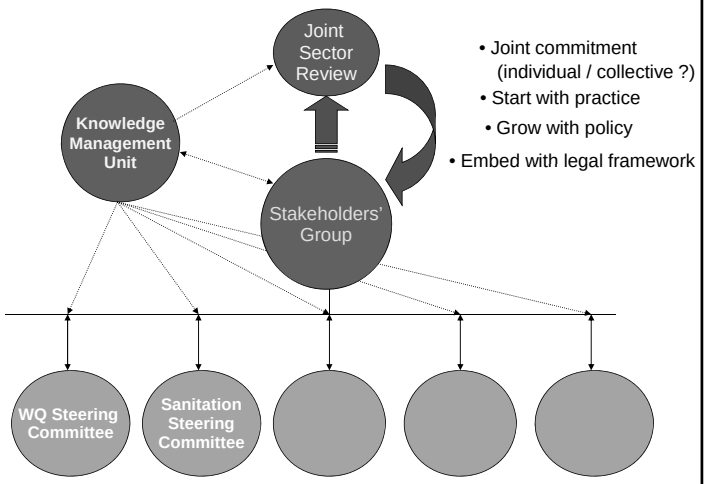
Improving Urban/ Semi- Urban Water Utilities Performance

Is there anything in this for the urban sector ?

- creation of water utilities networking – partnerships
- definition of water utility performance indicators for quantification of service delivery and performance monitoring – systematic monitoring and publication against such indicators

this entails inter-utility/ inter-town competitiveness, improves accountability, generates demand and subsequent increase in sector finance

- monitoring consumer satisfaction, consumer response, pro-poor service
- promoting public-private-partnership for gain in efficiency, effectiveness and consumer satisfaction



…….. Next steps

Next Steps

- DWSS, good way forward, let us see how
- Fund Board: part of our covenant, will do next few months
- DoliDAR: SWAP on the road, we will consult all
- NEWAH: ?improve the sector? Role of NGOs, Health sector process
- JICA: yes, supportive, how to establish the mechanism?
- KVWSMB: involve urban sector, partnership/harmonization
- ADB: dialogue towards SWAP, functioning SSG, momentum

MIS unit effective enough? Fund flow .., hired 21 engineers

Capacity of service providers (incl. NGOs), performance/ benchmarking. ADB Social and environment framework

Next Steps

- World Bank: welcome that all issues are on the table, operationalize M&E, develop indicators for the sector,
- NWSC: health and water SWAP? Differences? Performance achievement? Collaboration between H&W sector
- PPPUE: very useful instrument for SWAP strengthening, involve private sector:
- Finland Embassy/FINNIDA: Education experience, include MLD.
- UN-Habitat: Data management, >> monitoring, joint programming, helps for mobilizing funds (bharatpur/joint)

Next Steps

- Lumanti: emphasis needed on urban, crowded, investment plans inadequate
- CBWSSP: action → coordination/high level committee, agree and sign: commitment for all
- NPC: positive, move forward, inform higher level decision makers
- ADDCN: Policy versus implementation, lack/retention of tech. staff
- SNV: CB/capacity strengthening, process with structural hurdles/competition (good and bad), learn, be open for experience and knowledge, KM good start, asset management and service provision, improve quality

What does CB mean for sustainability for assets, water resources, etc.

Who should be there: associations (FEDWASUN), communities, etc.

Interactive processes to benefit all/the SWAP process

Next Steps

- UNICEF: UNDAF provides support and direction, we are keen to support. Hard work, open to fresh thinking.
- WECS: WR/IWRM policy & practice
- NAVIN: DCs, need extra support

- Helvetas: SWAP timely and inevitable, use transport sector strategy, lots of useful information in process, consultation, documentation, manuals : IWRM, competing water needs, WUMP critical tool

Next Steps

- WaterAid: come together and make things happen, raise accountability, enhance response by public entities
- DDG DWSS: regulatory framework, functioning of pool fund, formula based allocation at local government level

- Takes time, let us see how we can manage to speed up

Next Steps

- We will circulate all presentations as well as this discussion to all whose e-mail addresses we have, this evening!
- Next meeting November 8,? 2008
- In the interim there will be committee meetings/collaboration with Dolidar Swap/PPTA Emerging Towns and other opportunities to learn for a better developed SWAP process approach
- WE NEED YOUR ENCOURAGEMENT AND HELP!

- Secretary MPPW

Presentation Outline

- Sector Environment
- Existing Institutional Arrangement
- Existing Coordination Arrangement
- A Need for Catalyzing Change
- Sector Wide Approach (Tanzanian Experience -WSDP)
- Our case
- Carrying knowledge management forward
- Next steps

Sector Environment

- **Fragmented sector**
  - There are a multitude of agencies, and equal if not more models of operation
- **Coverage disputed due to varying definitions**
  - Water Plan defines coverage vis-à-vis service levels
  - Assuming business as usual, both water and sanitation national 2017 targets will be missed (see graph)
- **Policy guided by a 3-yr Interim Plan**
  - Introduction of necessary policy, institutional and legal reforms adopting **Sector Wide Approach** through effective coordination between stakeholders (Point 7)
  - The **SSG will be made active** for effective coordination between water and sanitation agencies
- **Operating policy framework**
  - PRSP/Tenth Plan, MTEF
  - RWSS Policy-2004
  - Drafts on urban and sanitation policy being prepared
  - Policy promotes decentralization of service delivery through increased linkage with LGs

……Sector Environment

- **Sector Financing**
  - Declining sector budget as a % of total development budget since 2006/07 (HDR recommends at least 1% of GDP)
  - 67% of sector budget is financed through external aid
  - Disproportionate share of expenditure on sanitation (20% on rural sanitation)
  - Financing gap: US$ 46m/year
  - No complete picture – piecemeal approach
- **Slow pace of urban reforms**
  - Melamchi Project and Kathmandu Urban Water Management Project unbundled
  - ADB's TA on emerging towns
  - Local boards likely to emerge – policy gap
- **Monitoring**
  - Remains weak for both policy monitoring and project monitoring
  - Functional status Vs Coverage
- **Quality**
  - Nepal's own standards on drinking water quality – weak compliance
  - Drinking water supplied is questionable even in the cities
  - Poor quality of drinking water implies that benefits are not fully realized



नेपाल सरकार

स्थानीय विकास मन्त्रालय

स्थानीय प"र्वाधार विकास तथा कृषि सडक विभाग

सस्पेन्सन बृज डिभिजन

श्रीमहल, पुल्चोक, ललितपुर

फोन नं. ५५२४६८१, ५५२४६८२

फ्याक्स नं. ५५२७९४४, ईमेल: **sbdgov@gmail.com**

नेपालमा झोलुङ्गे पुलको विकास

पृष्ठभूमी

- शताब्दियौं देखि घाट तथा जंघारहरुमा झोलुङ्गे पुलको निर्माण
- एक लाख भिन्न भिन्न
- करिब ६००० जति नदीनालाहरु
- हिमाली र पहाडी क्षेत्रमा बसोबास गर्ने कयौं समुदाय वर्षायाममा एक अर्काबाट सम्पर्कविहिन
- वर्ष भरी तर्न नसकिने ठूला नदीहरुमा पनि काठको साँघु, वावियोको डोरी र तुइनबाट नदी तर्ने क्रममा अकालमा मृत्यूवरण
- भू-वनोट र भौगर्भिक चुनौतीका कारण ती क्षेत्रहरुलाई आगामी धेरै वर्षसम्म पनि सडकबाट जोड्न नसकिने स्पष्ट
- झोलुङ्गे पुल ती जनताहरुको जीवनको अभिन्न अंग

नेपालमा झोलुङ्गे पुलको विकासक्रम

- नदी तर्नको लागि सुरुमा सिंगा काठका मुढाहरु तेर्स्याएर सुरक्षित साँघु निर्माण
- बाँस र काठे (Cantilever) पुलहरुको प्रयोग
- फराकिलो ठाउँमा लहरा, चोया, बेत (Reed) को सँाघु
- कालान्तरमा फलाम र फलामे सिक्री
- भारतबाट फर्केका एकजना बाग्लुङे नेपालीबाट कलकत्तामा पानी जहाजमा चढ्ने फत्ता (Gangplank) को देखासिकी गरी सिक्रीको पुल निर्माण
- सिक्रीको पुल महंगो थियो, रिंगटा लाग्ने गरी हल्लिन्थ्यो तर सुरक्षित र टिकाउ थियो।
- फलामे लट्ठा आएपछि ठाउँ ठाउँमा घिर्लिंग झुन्ड्याई फराकिलो नदीहरु पार।
- घिर्लिंग फलामे लट्ठाको बीच भागसम्म लट्किएर आफै तानिन्छ। बाँकी आधा भाग यात्रु आफैले अर्को किनारसम्म तान्नुपर्छ। घिर्लिंग, पुल जस्तो उपयोगी र सुबिधाजनक हुँदैन। यो जोखिमपूर्ण पनि हुन्छ।

आधुनिक झोलुङ्गे पुल निर्माणको सुरुवात

- बीसौं शताब्दिको सुरुमा तयारी "स्कटिस" पुलहरु सीमित संख्यामा आयात गरिन्थे र ब्यापारिक तथा प्रशासनिकरुपमा महत्वपूर्ण बाटोहरुमा जडान गरिन्थे। यस्ता पुलहरु जम्मा २९ वटा बनाइएका थिए।

- सम्बत् २००७ पछि नेपालको विदेशी सहयोग संस्थाहरुसँगको सम्पर्क वृद्धी भयो र विकास योजनाहरुको सुरुवात पनि भयो। संयुक्त राष्ट्र संघ विकास कार्यक्रमले (UNDP) विकास योजनाहरुमा सहायता गर्न एक जना स्वीस नागरिक टोनी हेगनलाई खटायो।

आधुनिक झोलुङ्गे पुल निर्माणको सुरुवात

- सन् १९५८ मा युनाइटेड स्टेट्स अपरेसन मिसन (United States Operation Mission-USOM) मार्फत झोलुङ्गे पुल निर्माण गर्ने योजना शुरु गरियो । स्वीसहरु सन् १९६० देखि कार्यक्रममा सहभागी भए । सन् १९६० देखि १९६४ सम्म स्वीस ईन्जिनियरहरुले नेपालमा अमेरिकनहरुसँग सहकार्य गरे । यो सरकारी कार्यक्रमसँग सम्बन्धित थिएन । फलामे सिक्रीहरु फलामे लट्ठाले विस्थापित भए । पुल निर्माण कार्य केन्द्र सरकारले योजनाबद्ध विकासको (Planned Development Intervention) रुपमा संचालन गर्न थाल्यो ।
- सन् १९६४ मा सरकारले सार्वजनिक निर्माण विभाग अन्तर्गत सस्पेन्सन बृज डिभिजनको (Suspension Bridge Division-SBD) स्थापना गऱ्यो । पछि सस्पेन्सन बृज डिभिजनलाई सडक विभागमा गाभियो । हाल फेरी यो डिभिजन स्थानीय विकास अन्तर्गत कार्यरत छ । सन् १९७२ देखि हेल्भेटास नेपाल (Helvetas Nepal) मार्फत स्वीस सरकार विकासा सहयोग (Swiss Agency for Development Cooperation-SDC) ले झोलुङ्गे पुल कार्यक्रमलाई सहायता गर्न सुरु गऱ्यो ।

झोलुङ्गे पुलको किसिम र स्तरः

- नेपालमा झोलुङ्गे पुलको नर्म्स र स्ट्याण्डर्डहरुको (Norms and Standards) विकासमा सस्पेन्सन बृज डिभिजनले अग्रगामी उन्नति गऱ्यो र सस्पेन्सन, सस्पेण्डेड, स्टे केबुल तथा स्टिल ट्रस पुलहरु बनायो ।
- सुरुमा स्वीस ईन्जिनियरहरुले प्रत्येक पुलका लागि अलग-अलग डिजाइन गर्दथे । पुलको चौडाई फरक-फरक हुन्थ्यो । एउटा पुलको फलामे सामग्री अर्को पुलको सामग्रीसँग मिल्दैनथ्यो । यी सबै काम कुराहरु गर्न धेरै समय र खर्च लाग्थ्यो । प्रति मिटर करिब ८०० अमेरिकी डलर खर्च हुन्थ्यो र वर्षमा ६ देखि १० वटा पुलहरु मात्र बन्ने गर्थे । समय बित्दै जाँदा सर्वेक्षण, डिजाइन, नक्साहरु र निर्माण प्रक्रियाहरु सरलीकरण तथा स्तरीकरण गर्नुपर्ने आवयकता स्पष्ट भयो । स्तरीकरणले पुलको डिजाइन गर्न, नक्सा बनाउन, पार्टपुर्जाहरु उत्पादन, निर्माण र मर्मतसम्भार गर्न लाग्ने समयको बचत भयो ।

झोलुङ्गे पुलको किसिम र स्तरः

- सस्पेन्सन बृज डिभिजनले सस्पेन्सन र सस्पेण्डेड दुई किसिमका पुल प्रविधि तथा स्ट्याण्डर्डको विकास गऱ्यो जसलाई एस.वि.डि. स्तर (SBD Standards) भनिन्थ्यो । स्थानीय पुल कार्यक्रमको सुरुवातसँगै सामुदायिक संलग्नता भएपछि, धेरै बस्तीहरु जोड्ने, स्थानीय अर्थतन्त्र र ग्रामिण जनताको जीविकोपार्जन विकासको लागि स्थानीय बाटाहरुमा समुदायले बनाउने सक्ने पुलहरुको माग अनपेक्षित रुपमा बढ्यो ।
- फराकिला नदीहरु वारपार गर्न डिजाइन गरिएका एस.वि.डि. स्तरका (SBD Standard) पुलहरु स्थानीय बाटाहरुमा न आवश्यक थियो, न लागतपरक थियो, न त समुदायहरुले बनाउन नै सक्दथे ।
- "समुदायले बनाउने सक्ने" प्रविधिको आवश्यकता महसूस गरेर हेल्भेटास नेपालले परम्परागत बाग्लुङ पुलहरुको डिजाइनमा आधारित एउटा बेग्लै डिजाइन विकास गऱ्यो । स्थानीय सीप र सामाग्रीहरुको उच्चतम प्रयोगमा आधारित यो नयाँ डिजाइनमा टिकाउ र प्रयोगको हिसाबमा सबै ईन्जिनियरिङ्ग मापदण्डहरुको पनि पालना गरिएको हुन्छ । यसरी स्थानीय स्तरको पुल निर्माण प्रविधि (BBLL Technology) र समुदायमा आधारित कार्यान्वयन प्रक्रिया लागु भएपछि पुलको लागत प्रति मिटर अमेरिकी डलर १७५ मा झऱ्यो र आश्चर्यजनक तरिकाले वर्षमा २०० वटा पुलहरु बन्न थाले ।

छोटो र लामो तरिको झोलुङ्गे पुलहरुः

- स्थानीय स्तरमा पुल निर्माण कार्यक्रम परिपक्व हुँदै जाँदा, स्थानीय स्तरको पुल निर्माण प्रविधिको (BBLL Technology) आधारमा अझ कम खर्च लाग्ने र प्राविधिक तवरले अति सरल तर टिकाउ छोटो तरिको झोलुङ्गे पुलको विकास भयो । पहिले स्थानीय स्तरको (BBLL Bridges) भनिने पुलहरुलाई हाल छोटो तरिका झोलुङ्गे पुल (Short Span Trail Bridge-SSTB) भनिन्छ ।

- छोटो तरिको पुलको स्ट्याण्डर्ड विकास गर्ने क्रममा प्राप्त अनुभवहरुको आधारमा एस.वि.डि.स्तरको प्रविधि (SBD Technology) लाई परिमार्जित गरी लामो तरिको झोलुङ्गे पुलको नयाँ स्ट्याण्डर्ड कायम गरियो । पहिले एस.वि.डि. स्तरको (SBD Bridges) भनिने ती पुलहरुलाई हाल लामो तरिको झोलुङ्गे पुल (Long Span Trail Bridge-LSTB) भनिन्छ ।

- दुबै थरीका पुलका डिजाइनहरु एक आपसमा मिल्दोजुल्दो भएकोले कुन पुलको लागि कुन डिजाइन र स्ट्याण्डर्ड लागु गर्ने भनी सीमाङ्कन गर्न आवश्यक भयो ।

- छोटो तरिको झोलुङ्गे पुलको लागत कम भएको तर्कले यसको अधिकतम प्रयोग गरिनु उचित हुन्छ । छोटो तरिका झोलुङ्गे पुल १२० मिटरसम्म सुरक्षित तरिकाले निर्माण गर्न सकिने कुरा प्राविधिक रुपमा स्पष्ट देखियो । १२० मिटर भन्दा लामो पुल बनाउनु पर्दा लामो तरिको झोलुङ्गे पुलको डिजाइन प्रयोग गर्नुपर्दछ ।

सस्पेन्सन् बृज डिभिजनः-

- सस्पेन्सन बृज डिभिजन केन्द्रीय तहमा पुल "उत्पादन गर्ने" संस्थाको रुपमा स्थापना भयो । स्थानीय दृष्टिकोणबाट हेर्दा यसले मात्र अनुरोधको आधारमा पुलहरु बनाइदिन्छ भन्ने कुराले पुलको माग स्वतः ओइरियो ।

- सस्पेन्सन बृज डिभिजन शुरु हुँदा प्रत्येक विकास क्षेत्रमा एक-एक जनाका दरले पाँचजना स्वीस विशेषज्ञहरु थिए । उनीहरु सरकारबाट नियुक्त एकजना नेपाली योजना प्रमुख, ईन्जिनियरहरु, ड्राफ्ट्स्म्यानहरु, प्रशासकीय तथा लेखा कर्मचारीहरुसँगै काम गर्थे ।

- सुरुमा क्षमता अभिवृद्धि गर्नुपर्ने आवश्यकता महसुस गरी फलामे लट्ठाको प्रयोग गरी बन्ने आधुनिक पुलहरुको ("हाईटेक" पुल पनि भनिन्थ्यो) सर्वेक्षण, डिजाइन र नक्साङ्कन गर्ने नेपाली ईन्जिनियरहरुको प्राविधिक क्षमतामा अभिवृद्धि गरियो ।

- पश्चिमी मुलुकका विश्वविद्यालयहरुमा भूगर्भ शास्त्र, स्ट्रक्चरल ईन्जिनियरिङ्ग र निर्माण व्यवस्थापन विषयमा प्रदान गरिएका स्नातकोत्तरतहका छात्रवृत्तिहरुले सरकारी ईन्जिनियरहरुमा नयाँ चुनौतीहरुको सामना गर्न सक्ने क्षमता वृद्धि गऱ्यो ।

- सन् १९९० को दशकको अन्त्यतिर नेपाली ईन्जिनियरहरु आफै स्थानीय आवश्यकता सुहाउँदो पुल डिजाइन गर्न सक्षम भए । यस पछि हेल्भेटास नेपालको संलग्नता एकजना प्रमुख प्राविधिक सल्लाहकार र थोरै सहयोगी कर्मचारीहरुमा समेटियो । सन् १९९० को मध्यतिर नेपाली ईन्जिनियरहरु प्राविधिक तथा योजना कार्यान्वयन गर्ने जिम्मेवारी आफैंले बहन गर्न सक्ने भए ।

ठोस उपलब्धीहरुः

- ६१ वडा पहाडी जिल्लाहरुका मूलबाटाहरुमा ७०० वटा पुलहरु निर्माण भए जसले मूलबाटाहरुको १२,००० कि.मी. संजाललाई वर्षभरी चालु राख्न सकियो ।
- प्रविधिको स्तरीकरण र दिग्दर्शनहरुको प्रकाशन गरियो ।
- योजना तर्जुमाका आधारहरु (Planning Tools) को विकास गरियो ।
- ५७ पहाडी जिल्लाका मूलबाटाहरु तथा केन्द्रिय सेवाहरुको नक्सा (Main Trail and Central Services Maps) तयार भयो ।
- जिल्लागत तथा क्षेत्रिय मूलबाटोका नक्साहरु (District-wise and Regional Main Trail Maps) तयार भयो ।
- जिल्लागत सेवा केन्द्रहरुका नक्साहरु (District-wise Center Maps) तयार गरियो ।
- मूलबाटाहरुमा भएका नदी तर्ने ठाउँ तथा पुलहरुको केन्द्रीय पुल रजिष्टर (Central Bridge Register of Crossing and Bridges along Main trails) तयार गरियो ।
- योजना तथा अनुगमन सूचना पद्धति (Planning and Monitoring Information System) को विकास गरियो ।
- सस्पेन्सन बृज डिभिजनको संलग्नतामा देशको मुलप्रवाहबाट बाहिर रहेका दोधारा र चाँदनी गा.वि.स.लाई सदरमुकाम संग सिधा जोड्न महाकाली नदीमा लगभग १.५ कि.मी. लामो मल्टी स्पान सस्पेन्सन बृजको निर्माण भयो । जो सायद संसारको सबैभन्दा लामो पैदल पुल हुन सक्छ ।
- यसका अतिरिक्त हालसम्म बनेकोमा एउटै स्पानका सबैभन्दा लामो सस्पेन्सन बृज मदन आश्रित झो.पु., चितवन, सबैभन्दा लामो सस्पेण्डेड बृज वुवाँजोर झो.पु (सुनकोशी नदी, खोटाङ) सम्पन्न भईसकेका छन् । साथै एउटै स्पानमा सबैभन्दा लामो मदन आश्रित झो.पु. भन्दा बढी लम्बाईका शिवालय झो.पु., जाजरकोट (भेरी नदी) त्रिवेणी गर्रास झो.पु. सिन्धुली निर्माणाधिन छन् भने सबै भन्दा फ्रि-बोर्ड भएको अर्थात खोलाको सतहबाट बढी अग्लाईमा रहेको कुश्मा-ज्ञादी झो.पु. पनि निर्माणाधिन छ ।
- आज ४,००० भन्दा बढी सुरक्षित, एवं टिकाउ पुलहरुले देशभरीका नदी-किनाराहरुलाई जोडेका छन् । ४,००० वटा पुलको लम्बाई एकै ठाउँमा जोड्ने हो भने २८० कि.मी. भन्दा बढी हुन्छ । त्यसमा हरेक वर्ष करिब २०० वटा अरु पुलहरु थपिन्छन् । आज, केही अति दुर्गम क्षेत्रहरुमा बाहेक, धेरै जसो ठाउँमा एउटा न एउटा नदी तर्ने सुरक्षित साँघु फेलापार्न तीन घण्टाभन्दा बढी हिंड्नु पर्दैन । यो दुरीलाई १ घण्टाको फेरोमा घटाई झोलुङ्गे पुल निर्माण गर्ने गरी झोलुङ्गे पुल रणनीतिको कार्यान्वयन गरिएको छ ।

भावी रणनीतिः

- झोलुङ्गे पुल निर्माण तथा मर्मत कार्यलाई स्थानीय निकायमा हस्तान्तरण गर्ने नीति अनुरुप झोलुङ्गे पुल रणनीति २०६२ तयार गरी लागु गरिएको छ । सो अनुसार झोलुङ्गे पुललाई जिल्ला यातायात गुरुयोजनामा समावेश गरी झोलुङ्गे पुल कार्यक्रम र सो को निर्माणको लागि आवश्यक श्रोत स्थानीय निकायमा निक्षेपण गरिने छन् ।

- स्थानीय निकायले स्थानीय समुदाय र गैरसरकारी संस्था समेतको सहयोगमा केन्द्रबाट प्राप्त हुने श्रोत स्थानीय निकायको रकम र समुदाय समेतको जनसहभागितामा झोलुङ्गे पुल निर्माण गर्दछ ।

- झोलुङ्गे पुलसँग सम्बद्ध विभिन्न संस्थाहरुले अपनाउने प्रविधि, स्टेण्डर्ड, नर्म्स तथा स्पेसीफिकेशनमा एकरुपता ल्याई समान कार्यान्वयन प्रकृया अवलम्बन गराईने तथा झो.पु. निर्माणमा संलग्न निकायहरुको सम्पूर्ण श्रोत परिचालन एकद्वार प्रणालीबाट गरिने छ ।

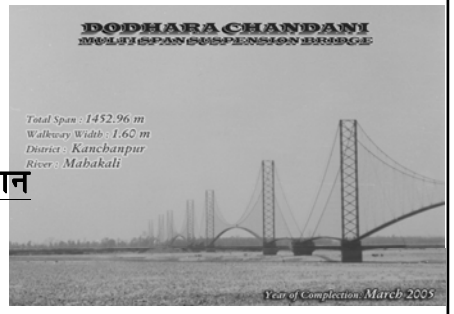
- जिल्लाको प्राविधिक क्षमता, संस्थागत क्षमता र आर्थिक श्रोतबाट धान्न नसकिने जटिल प्रकृतिका रणनीतिक हिसाबले महत्वपूर्ण स्थानमा रहेका र बहुतरी (Multi-Span) का झो.पु.हरुको निर्माण कार्य भने सस्पेन्सन बृज डिभिजनबाट गरिने छ । झोलुङ्गे पुल रणनीति २०६२ अनुसार लामो तथा छोटो तरी (SSTB & LSTBB) का पुल निर्माण कार्य स्थानीय समुदायको सहभागितामा जिल्ला विकास समिति मार्फत गरिने गरी विकेन्द्रित गरिएकोले अब सस्पेन्सन बृज डिभिजनबाट जिल्लाको प्राविधिक, आर्थिक र संस्थागत क्षमताले नधान्ने बढी लम्बाईका, जटिल प्रविधियुक्त र बहुतरी (Multispan) झोलुङ्गे पुल मात्र निर्माण गर्ने र झो.पु. निर्माणको लागि जिल्लाबाट माग भै आएमा प्राविधिक सहयोग उपलब्ध गराउने काम हुने गर्दछ ।

- हालसम्म सस्पेन्सन बृज डिभिजनबाट ७०० वटा झो.पु. निर्माण कार्य सम्पन्न भैसकेको छ भने २० वटा झो.पु.हरु निर्माणाधिन छन् । प्रत्येक वर्ष बजेटको उपलब्धता अनुसार ६ देखि १० वटा नयाँ र जटिल प्रकृतिको पुलहरु सम्पन्न गर्ने लक्ष्य रहेको छ ।

- सस्पेन्सन बृज डिभिजनले ठेक्का पट्टा प्रणालीबाट निर्माण व्यवसायीहरुद्वारा Turn-Key Package मा झो.पु. निर्माण कार्य गर्दछ । यस प्रणालीमा निर्माणस्थलको सिभिल निर्माण कार्य, स्टील पार्टस्को Fabrication गर्ने कार्य सम्पूर्ण झो.पु. जडान गर्ने कार्य तथा झो.पु. निर्माणको लागि आवश्यक सम्पूर्ण प्राविधिक जनशक्तिको र सुपरभिजनको जिम्मा निर्माण व्यवसायीको हुने छ ।

Facts & Figures

सबै भन्दा लामो झोलुङ्गे पुल



दोधारा चाँदनी मल्टी स्पान झोलुङ्गे पुल, कन्चनपुर

स्पानः १४५२.९२ मीटर

महाकाली नदी

टावरः ८ वटा, हिड्ने बाटोको चौडाईः १.६० मी.

सस्पेन्सन् बृज डिभिजनबाट निर्माण गरेको । (नेपाल सरकारको मात्र लगानीमा)

Facts & Figures

सस्पेन्सन बृजमा सबैभन्दा लामो स्पान भएको

मदन आश्रित झोलुङ्गे पुल, तनहुँ र चितवन,
स्पानः २७१ मीटर, त्रिशुली नदी
सस्पेन्सन् बृज डिभिजनबाट निर्माण गरेको ।

Facts & Figures

सस्पेन्डेड बृजमा सबै भन्दा लामो स्पान भएको

बुंवाजोर झोलुङ्गे पुल, खोटाङ
स्पानः ३५० मीटर, सुनकोशी नदी
सस्पेन्सन् बृज डिभिजनबाट निर्माण गरेको ।

Facts & Figures

सबै भन्दा बढी उचाईमा रहेको झोलुङ्गे पुल

चुनिलेडर झोलुङ्गे पुल, मनाङ
स्पानः ८५ मी., सस्पेन्डेड
४२०० मी. उचाईमा रहेको ।
सस्पेन्सन् बृज डिभिजनबाट निर्माण गरेको ।

Fact s& Figures

सबै भन्दा बिकट ठाउँमा रहेको झोलुङ्गे पुल (भरिया दिन अनुसार)

हिल्सा झोलुङ्गे पुल, हुम्ला
स्पानः- ११७.४० मी., सस्पेन्सन, कर्णाली नदी
सस्पेन्सन् बृज डिभिजनबाट निर्माण गरेको ।
२२ भरिया दिन लाग्ने ।

देवघाट झो.पु.,
चितवन/तनहुँ

सबैभन्दा फ्रि बोड भएको
कुश्मा ज्ञादी झो.पु.
पर्वत

सबैभन्दा फ्रि बोड भएको
कुश्मा ज्ञादी झो.पु.
पर्वत

Facts & Figures

स.बृ.डि.को अमलेखगंज स्थित लट्ठा (Wireropes) स्टोर

अन्य

लामो तरीको झोलुङ्गे पुल	३०० वटा
छोटो तरीको झोलुङ्गे पुल	३७०० वटा
जम्मा	४००० वटा

जसमध्ये

सस्पेन्सन टाइपको	६१० वटा
सस्पेन्डेड टाइपको	३००० वटा
स्टील ट्रस बृज	१४५ वटा
अन्य किसिमको	२४५ वटा
जम्मा	४००० वटा

उपसंहार

- देशका विकट भू-भागका बासिन्दाहरुलाई एकापसमा जोडि आर्थिक, सामाजिक र राजनैतिक जीवनका विविध पक्षमा सुगमता ल्याई जनधनको क्षती हुनबाट बचाउन सडक यातायातले नछोएका हाम्रा हिमाली र पहाडी भेगको लागि झो.पु. निसन्देह यातायातको निर्विकल्प र महत्वपूर्ण संरचना हो ।
- नेपालमा झो.पु. निर्माणको सुरुवात देखि आजसम्मको अवधिमा सक्रिय र महत्वपूर्ण भूमीका निवाह गरेको सस्पेन्सन बृज डिभिजनलाई अझै सशक्त र प्रभावकारी ढंगले अगाडी बढाउन यसको संरचना र संस्थागत क्षमतामा अभिवृद्धि र आधुनिकीकरण गर्नुपर्ने देखिन्छ ।
- साना र मझौला झो.पु. कार्यक्रमलाई जिल्लामा बिकेन्द्रीत गरिएता पनि ठूला र जटिल प्रकृतिका झो.पु. निर्माण गर्न, झो.पु. सम्बन्धी प्रविधिको विकास गर्न र विदेशमा निर्यात गरी झो.पु. निर्माणमा नेपाललाई अग्रणी राष्ट्रको रुपमा चिनाउन केन्द्रमा एक शसक्त र प्रभावकारी संस्थाको जरुरी पर्दछ । अहिलेको अवस्थामा त्यो संस्था भनेको निसन्देह सस्पेन्सन बृज डिभिजन नै हो ।

सस्पेन्सन् बृज डिभिजन

श्रीमहल, पुल्चोक
फोन नं. ५५२४६८१/८२

धन्यवाद

Questions/Comments

Annex III

Questions and comments penned by the participants

- What is 2009 Tracking survey? Is it representative for Nepal?
- Why is the CPR target presented for 2015 – 67% different from the Result Matrix – NHSP II?
- The MMR figure 229 is not a national but 8 district average. National is 281 from NDHS 2006

- What about the Mental Health in MDG and why is it excluded?
- Whether Mental Health is cross cutting issue?
- What about Health- Physical, Mental and Social?

- The Nepal fertility, Family Planning and Health Status Survey (NFFPHSS) was conducted in 1991 not 1990and was funded by UNFPA. The MMR – 515 was based on Sisterhood Indirect Method, while MMR – 534 and MMR – 281 was based on Sisterhood Direct Method.
- Met need for C- Section is increasing. It was 20% (NDHS 2001) and 54% (NDHS 2006) (Based on the assumption that 5% deliveries would need C-section)

- Dr. Marasini mentioned the importance of school health nutrition Program for achieving the MDGs. How can we ensure a scale up of funds for the school health nutritional program? How to better coordinate MoES and MoHP?

- Decreasing poverty gap is good achievement, however this achievement sounds questionable based on current situation of the country. Also this achievement might hurdle to get external support in future, to improve existing poverty in country

- Is there a chance for getting SBA training to ANMs working in NGO clinics for achieving MDG in shorter time?

Questions and comments penned by the participants

- How do health related INGOs report their contribution (financial/technical) to the MoHP so that these contribution can be reflected in the overall health budget
- How do health related INGOS that operate at the districts level ensure that the program priorities are linked to district health services provided by MoHP to avoid duplication

- Blood banking is one of the components to be improved to achieve MDG 5. Five year National Strategic Plan for Strengthening Blood Transfusion Service in Nepal has been developed with combined effort of National Public Health Laboratory (focal point for blood safety for MoHP (GoN) and Nepal Red Cross Society (NRCS).
  Now, the question is: Can GoN, MoHP provide financial resource to implement five year national strategic plan ultimately to strengthen BTS in Nepal?

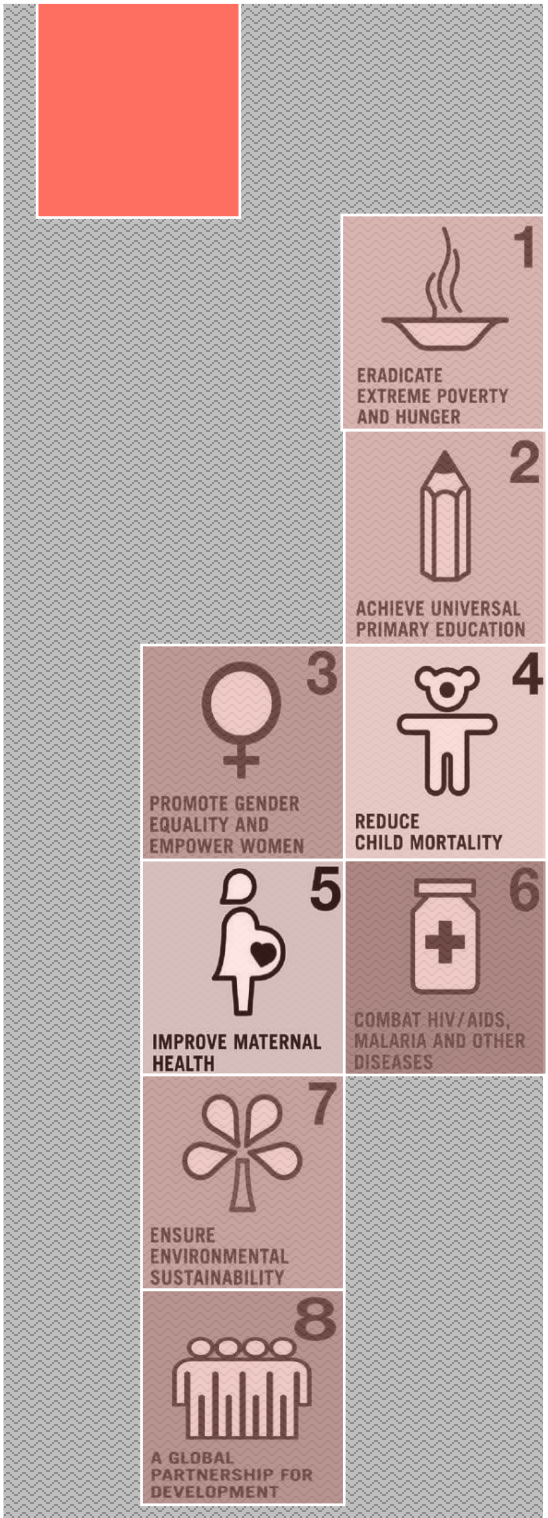
Participants List

Annex IV

Monitoring MDG Progress : Health sector and beyond

Interaction Programme Participants List

S.n	Name	Organization
1	Hon. Dr. Yuvraj Khatiwada	NPC Vice Chair
2	Hon. Dr. Chet Raj Pant	NPC Member
3	Dr. Laxmi Raj Pathak	Act. Secretary, MOHP
4	Dr. Jagadish C. Pokharel	Ex-vice chair, NPC
5	Dr. Senendra Upreti	Joint Secretary, MOHP
6	Mr. Surya P Acharya	Joint Secretary, MOHP
7	Dr. B. R. Marasini	Chief HeSRU/MOHP
8	Mr. Yogendra Gauchan	Undersecretary, MOHP
9	Dr. Anand Shrestha	MOHP
10	Shivendra Pandey	MOHP
11	B B Thapa	MOHP
12	Dr. K.R. Parajuli	MOHP
13	Ms. Sirjana Gyawaly	MOHP
14	Mr. Bal Sagar Giri	Legal Officer, MOHP
15	Mr. Arjun B Singh	Director, NHTC
16	Dr. Radha Raman	Director, DDA
17	Dr.Lok Raj Paneru	Management Division/DoHS
18	Pranay Upadhyay	EDCD/DoHS
19	Mr. Suman P Sharma	Joint Secretary, MOPPW
20	Mr. Mani Ram Gelal	Project Manager, Suspension Bridge Division, DoLIDAR
21	Dr. C.L Bhusal	NHRC
22	Mr. Sudip Pokhrel	Consultant (Programme Facilitator)
23	Mr. Bhimsen Devkota	Consultant
24	Mr. Ian McFarlane	UNFPA (EDP Co-chair)
25	Ms. Chonghee Choi	UNFPA
26	Dr. Peden Pradhan	UNFPA
27	Dr. Maria Elena	UNAIDS
28	Ms. Bina Pokhrel	UNAIDS
29	Dr. Nihal Singh	WHO
30	Dr. Nirmal Kandel	WHO
31	Dr. Shushil Pant	WHO
32	Dr. Gunawan Setiadi	WHO
33	Dr. Suraj Shrestha	WHO
34	Dr. Gangaram Chaudhary	WHO- IPD
35	Mr. Clifford Lubitz	USAID
36	Mr. Greg Whital	SSMP
37	Mr. Ajit Pradhan	SSMP
38	Mr. Sunil Khadka	SSMP
39	Dr. Amit Bhandari	Save the Children
40	Dr. Lochana Shrestha	Save the Children
41	Dr. Neena Khadka	Save the Children
42	Mr. Ashutosh Tiwari	Water Aid
43	Mr. Om P Gautam	Water Aid
44	Ms.Suzanne Walton	UMN
45	Mr. Bhagwan Shrestha	FHI/ Asha Project
46	Mr. Madhu Sudan Satyal	FHI/ Asha Project
47	Ms. Chanda Rai	CCS Italy
48	Mr. Simone Galimberti	CCS Italy
49	Mr. Gopal K Nakarmi	World Neighbors
50	Dr. Bhanu Niraula	BNMT
51	Mr. Vivek Singh	BNMT
52	Mr. Netra Bhatta	ADRA
53	Dr. Kokila Vaidya	PSI
54	Ms. Gabriele Mullapathy	MLI
55	Mr. Babu Ram Shrestha	SAP Nepal
56	Mr. Jhabindra Bhandari	CARE
57	Mr. Arjun Aryal	CARE
58	Ms. Geeta Pradhan	LWF Nepal
59	Mr. Shanta Lall Mulmi	RECPHEC
60	Mr. Matrika Devkota	Koshish
61	Mr. Sanjay Neupane	Koshish
62	Ms. Savitri Gurung	Consultant
63	Ms. Reshma Shrestha	AIN
64	Dr. KK	NTC
65	Dr. T. R. Adhikari	



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