Health Need Assessment of Nepalgunj Sub Metropolitan, Panchadewal Binayak and Triveni Municipalities
2025

Submitted to:
Municipality Association Nepal (MuAN)

Submitted by:
Sagar Dahal

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List of Abbreviations

ANC:	Antenatal Care
BCG:	Bacillus Calmette Guerin
B.S.:	Bikram Sambat
BHSC:	Basic Health Service Center
CHU:	Community Health Unit
DHS:	Demographic Health Survey
FRA:	Fiduciary Risk Assessment
GESI:	Gender Equality and Social Inclusion
HFOMC:	Health facility operation and management committee
HP:	Health Post
HMIS:	Health Management Information System
KII:	Key Informant Interviews
LISA:	Local Government Institutional Capacity Self-Assessment
MoFAGA:	Ministry of Federal Affairs and General Administration
MSS:	Minimum Service Standards
MuAN:	Municipal Association of Nepal
NHSSP:	Nepal Health Sector Strategic Plan
OAG:	Office of the Auditor General
PCV:	Pneumococcal Vaccine
PHC:	Primary Health Center
S2HSS-II:	Support to the Health Sector Strategy
S2GESI:	Support to Gender Equality and Social Inclusion
TFR:	Total Fertility Rate
TOR:	Terms of Reference
MHCC:	Multisectoral Health Coordination Committee
UHC:	Urban Health Center

Introduction:

The Municipal Association of Nepal (MuAN), established in 1994 under the National Directive Act 1961, serves as the umbrella organization representing all municipalities across Nepal. With a proven track record in policy reform and advocacy, MuAN has emerged as a credible national voice for municipalities, particularly in areas of decentralization, governance, poverty alleviation, gender equity, and environmental sustainability.

Aligned with its five-year Strategic Plan (2081–2085), MuAN is implementing a project focused on strengthening local governance through improved health service delivery. This initiative is supported by the Nepal-German bilateral program—Support to the Health Sector Strategy (S2HSS-II) and Support to Gender Equality and Social Inclusion (S2GESI). The project is closely aligned with the Nepal Health Sector Strategic Plan (NHSSP) 2023–2030, emphasizing evidence-based health management and GESI integration at the municipal level.

Despite constitutional and policy commitments to free basic health care services as fundamental right, municipalities face persistent challenges in implementing it effectively due to several reasons including; fragmented coordination across sectors, limited technical capacity and planning tools, inadequate integration of GESI principles, gaps in accountability and resource mobilization. Recognizing that effective health governance is foundational to equitable and quality health services, this quick assessment aims complement the project to identify systemic and operational gaps in selected three municipalities Nepalgunj Metropolitan, Panchadewal Binayak and Triveni Municipalities in delivering Basic Health Care Services.

Objective

To assess gaps in the implementation of basic health services at the municipal level and identify opportunities for strengthening health governance through a multisectoral and GESI-sensitive approach.

Methodology

The assessment has adopted a mix methods including the following;

1. **Document Review:** A wide array of municipal and government documents was analyzed, including Local Government Institutional Capacity Self-Assessment (LISA), Fiduciary Risk Assessment (FRA) reports accessed through the Ministry of Federal Affairs and General Administration (MoFAGA) portal, Audit Report of OAG, Budget Speech and Redbook, Annual Health Reports of municipalities and District Health Offices, as well as Social Audit and Public Hearing reports. Presentations delivered by municipalities during review meetings were also critically examined.
2. **Key Informant Interviews (KII)**

In-depth interviews were conducted with six municipal stakeholders, including Health Section Chiefs and other relevant team members, to gather insights into operational practices, governance challenges, and service delivery mechanisms.

3. **Sensitization Workshop Insights**

The findings incorporated qualitative insights derived from presentations and subsequent discussions held during sensitization workshops, reflecting participants perspectives on municipal health governance.

Section 1: Panchdewal Binayak Municipality

Background Features

Panchadewal Binayak Municipality, situated in Achham District of Sudurpaschim Province, covers 147.75 km² across 9 wards and is home to 26,088 residents (11,893 males and 14,195 females). The area includes 3,274 children under five and 655 under one, along with 1,165 individuals with disabilities. Marginalized communities form a significant part of the population: 6,419 Dalits (Kami, Sarki, Badi), making up 24.6%, and 7,063 Indigenous and other marginalized individuals, accounting for 27.1%. Based on its size and population, the population density stands at about 177 people per km².

According to the 2021 Census, the municipality is also affected by out-migration, in line with broader trends in Achham District, which recorded a negative population growth rate of –1.09%. Transportation plays a vital role in service delivery: health services rely on jeeps and motorcycles where roads allow, while more remote areas are accessible only via foot trails and porters for supply chain management. As per the KII, despite road expansions, many wards (especially Wards 7, 8, and 9) remain hard to access, some settlements requiring up to 6 hours of walking to reach a health facility. Public transport is available only in Wards 1 to 4, hindering access to healthcare. These logistical challenges affect emergency response, especially in critical cases or during harsh weather, making outreach efforts more difficult. Among the several social issues, the persistence of *Chhaupadi*—a deeply rooted practice of isolating menstruating women—continues to pose serious health and safety risks despite being legally banned. Many women and girls are forced to stay in unsanitary and unsafe sheds, exposing them to cold temperatures, respiratory illnesses, snake bites, and even sexual violence. The stigma surrounding menstruation also leads to poor menstrual hygiene, with limited access to sanitary products and inadequate WASH facilities in homes and schools.

Situation Analysis

The situational analysis evaluates the municipality's progress and performance across key health system building blocks. These include Health Infrastructure and Human Resources; the Policy Environment; Delivery of Basic Health Services; Health Financing; Governance and Planning; and Coordination and Collaboration.

Health Infrastructure and Human Resource

There are currently 13 public health institutions in the municipality i.e. eight approved health posts plus one Basic Health Service Center in Ward 2 while Community Health Units operate in Wards 6, 7, and 9, under the health posts and 1 Ayurvedic Aushadhalaya. There are two health posts under construction in Wards 1 and 6, co-funded equally by the Province and Municipality, and the existing Basic Health Service Center of Ward 2 is being upgraded into a primary-level hospital. The Health Section Chief has informed us that they are planning to operate it form this fiscal year. Though all the health post are run in their own building, only three facilities in Wards 4, 7, and 8 meet national infrastructure standard. The municipality has one ambulance service and four of its health facilities have laboratory services. Out of the total nine birthing centers, there are seven birthing centers that meet the prescribed standards, all the birthing centers have placenta pits, ensuring proper biomedical waste disposal. However, only three health facilities have staff quarters, and just nine are accessible by motor roads, which may limit emergency access. All nine wards have stretchers available, and as per the municipality most of the facilities lacked essential equipment. Only seven HPs have safe drinking water supply.

All sanctioned positions for the designated health facilities are fulfilled. The facilities combined have a total 45 sanctioned positions, with 37 filled permanently and 30 staff are on contract. As majority of the health facilities are previously operational HPs which has a sanctioned positions unlike BHSC and UHCs, so in managing the HR the municipality is not stretched out. However, retaining qualified medical professionals remains a challenge, particularly due to factors such as limited infrastructure, inadequate facilities, and low pay scales. There are not private health institutions in the municipality.

Health Policy Environment

As per the municipal presentation in sensitization workshop as well as from scan of Municipal web page the total of 49 legal and regulatory instruments has been reported to be developed but the policy instruments regarding health were only five. The same information was validated during the KII and the situation was well acknowledged with the remarks "The municipality currently lacks local-level health-specific laws or strategies, hindering effective health program development and enhancing health governance. A significant capacity constraint exists to formulate robust health policies. To address these gaps, planning initiatives are underway in collaboration with GIZ, focusing on developing a health policy and health sector strategy. The five health and sanitation related policy instruments developed by the municipality are; 1) Local health and sanitation act 2075 2) Drinking Water, Sanitation and Hygiene Act, 2024 and 3) Ambulance Operation and Management Procedure, 2082 (B.S.) and 5) Rural Ultrasound Service Operation Procedure, 2082 (B.S.)

Table 1 Legal Instruments Developed at Panchadewal Municipality

S. no.	Municipality	Act	Regulation	Guidelines/ procedure	Standard / code of conduct	Policies/Periodic plan	Total	Health and Sanitation Related
1	Panchadewal Binayak Municipality	20	2	19	2	6	49	5

Basic Health Services Delivery

The Basic health service has been catered through 13 health facilities, including HP, BHSC, and CHUs and Ayurvedic Aushadhalya. There are no private or non-governmental health institutions, or central-level health facilities operated within the area. All the BHS services offered through the HFs are free to the people. Municipality had also adopted a strategy to meet the health needs beyond basic health services through organization of outreach camps like Eye health campaign and surgical camps.

"Before, some facilities charged small fees for lab services. But after the 2079 (2022) elections, our new municipal head insisted all basic services be free, so we removed all charges."

– Health Section Chief, Panchadewal Municipality

The least developed service components for BHS reported in KII were mental health, rehabilitation services, NCDs and Ayurveda. The classical service like immunization, safe motherhood, family planning are provisioned well. Even the FP and Nutrition services at times suffered due to the interrupted essential supplies from the province. The federal allocation of the resource for procurement of medicines is only 15 lakhs the municipality use to top up this amount by around 10-15 lakhs annually which has enabled the municipality to maintain the stock of medicines needed for the delivery of BHS. Only Aminophylline Injection and Sulphamethoxazole-Trimethopirm tablets were out of stock throughout the year. NCD screening were done in all wards enabled to identify undiagnosed hypertension and diabetes cases. Mental health, and suicide prevention service can be considered underdeveloped.

Among the nine core components of basic health service delivery, most have been successfully implemented. However, the analysis below focuses solely on the service components for which data is available and analyzable through Nepal's Health Management Information System (HMIS).

Immunization coverage in the municipality has declined over recent years, with BCG coverage dropped to 65% in 2081/82, well below the national average of 96% (DHS 2022). Layanti was lowest among all others. The third dose of DPT-HepB-Hib also dropped to 57% by 2081/82 where Kuchhi had lowest coverage rate, compared to 64% at the district level and 93% nationally as per DHS 2022. Measles-Rubella 2 coverage also declined from 99% to 54% by 2081/82 where BHSC had the lowest coverage rate, which is significantly below the district average of 73.3% and the DHS 2022 figure of 88%. Other vaccines such as PCV3, FIPV2, and Japanese Encephalitis average just 54%, far below the national PCV3 rate of 91%. Persistent issues with vaccine wastage due to over-ordering continue to highlight the need for improved micro-planning, accurate population estimates, and stronger stock management. To mitigate these, municipality used to conduct full immunization declaration program on an annual basis, ensuring that no child has been missed.

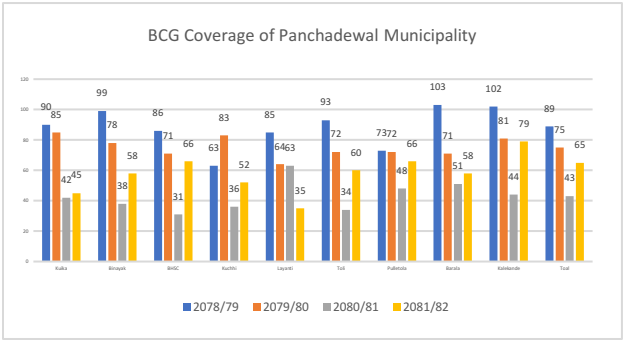


Figure 1:BCG Coverage 2080/81, Panchadewal Municipality

In Nutrition Service, the average attendance of children under 2 years in growth monitoring is quite good at 20 in 2081/82 even if declined by 2 percentage from the previous year. Exclusive breastfeeding in the municipality declined from 77% in FY 2078/79 to 73% in 2081/82, with compare to the district average it is below 11 percent for the fiscal year. Iron tablet distribution coverage to pregnant women also reported to be decreased in overall, though Pulletola, Kalekanda, Kuchi and Binayak showed some improvement in the last fiscal year. All the pregnant women of the municipality have received vitamin A dosing. The number of Severe Acute Malnutrition (SAM) in the municipality dropped significantly from 12 in 2078/79 to 1 in 2081/82, with all health posts achieving 100% recovery, outperforming the district's 82%. Although challenges remain in anemia, under nutrition, and adolescent nutrition issues still relevant at both district and municipal level.

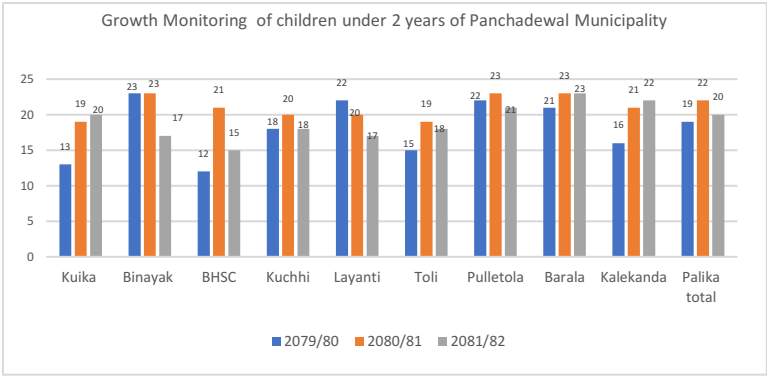


Figure 2: Average number of Growth Monitoring by Health Facility

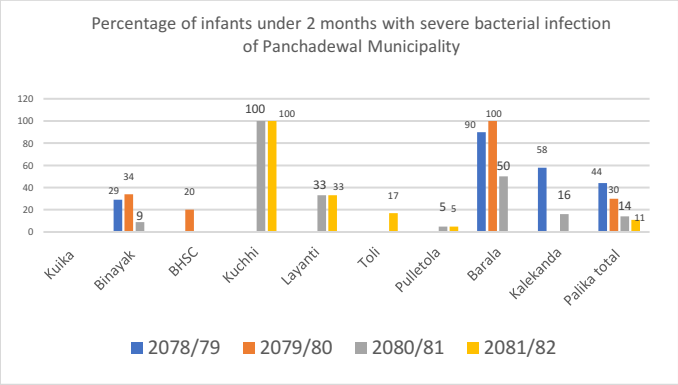


Figure 3: Percentage of infants under 2 months with severe bacterial infection.

The **child health services** are provided free of charge across all HFs. The prevalence of Severe Bacterial Infection (SBI) in infants under two months dropped from 44% to 11% in the municipality, with Kuchhi reporting the highest; in Achham district, SBI cases also declined from 18.5% in 2078/79 to 9.2% in 2080/81, showing similar progress. The incidence of respiratory illness declined from 397 of 2078/79 to 355 in 2081/82 per 1,000 under-five children, though Binayak still had the highest burden (765/1,000). According to the Demographic and Health Survey (DHS) 2022, respiratory infection prevalence nationally declined to 2.1%. Pneumonia was highest in Pulletola and lowest in Barala, with 100% antibiotic treatment coverage at both municipal and district levels. Diarrhea cases dropped significantly in both the municipality (from 215 to 48 per 1,000) and the district, with Layanti highest and Kuchhi lowest in FY 2081/82 in the municipality.

Regarding **maternal health services**, there are 9 birthing centers which indicates a good access to delivery services. Four ANC visits percentage declined from around 72% to 43% between FY 2078/79 and 2081/82, slightly below Achham district, which reported 48% and nationally 50% of women received four ANC visits as per DHS 2022. Barala had highest ANC visits while Toli had lowest ANC visits. In contrast, ANC 8 visits increased in the municipality from 19% to 42%, with Kalekanda and Pulletola leading, and Kuika reported lowest. Despite a good access, institutional deliveries also declined from 60% to 48%, similar to the district's drop from 67% to 58%. Kalekanda had the highest institutional delivery rate, while Kuika had the lowest at just 4% in FY 2081/82. Postnatal care within seven days was 45% in total, with Kalekanda highest at 68% and Kuchhi lowest. Low birth weight rate increased, with Barala reporting the highest rate. Safe abortion services in the municipality declined from 174 to 99 cases, unlike the district where services expanded from 861 to 1081. Child marriage remains a serious issue, with Barala having highest numbers of deliveries among girls under 20 in FY 2081/82. Alongside the ongoing Chaupadi tradition, this practice increases gender-based violence and negatively impacts maternal health by limiting women's access to care.

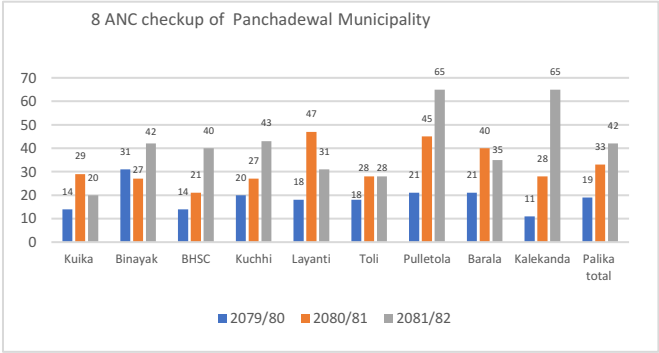


Figure 4:Percentage of women completing 8 ANC check-ups

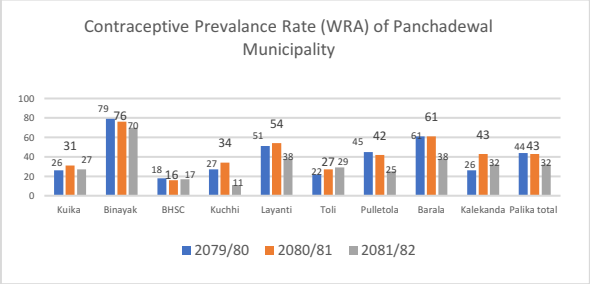


Figure 5: Contraceptive prevalence rate

In **Family planning** municipal data shows that the number of new users of modern contraceptives is in declining trend from FY 2078/79 to FY 2081/82, Kuchhi had only 11% with the lowest use of contraceptives.

Services related to **Infectious disease** From FY 2078/79 to 2081/82, TB case detection in the municipality improved overall, with Barala and Pulletola health posts showing the highest detection (over 100%). Treatment success constant to 100%, higher than Achham district's average of 88% and the national average of 91% (DHS 2022). Meanwhile, leprosy cases in the municipality showed a slight increase, similar to trends in Achham district, where scattered new cases persist, challenging to sustain the elimination at sub-national level. DHS 2022 also reported a modest national rise in new leprosy cases, especially in high-burden areas. These patterns highlight the need for focused local actions to meet Nepal's leprosy strategy targets, including zero child cases and prevalence under 1 per 10,000.

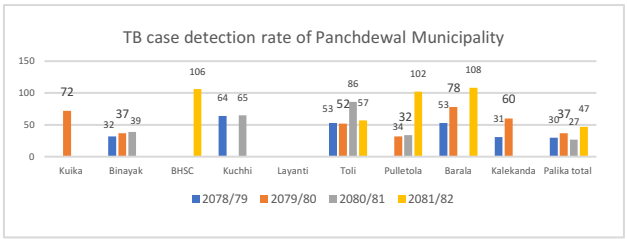


Figure 6: TB case notification rate notification rate

Provisioning of curative services with clinical diagnosis and treatment from the health facility is one of the important components of Basic service deliveries. According to Municipal presentation in sensitization workshop the data shows that in the fiscal year, a total of 13,890 new patients served as OPD cases in the municipality, with an overall 61% of the patients being female. On an average each facility served approximately 1,543 new OPD patients during the year and lowest of the same was observed in Toli and Kuika. The data suggests that female utilization of outpatient services remains strong in most areas as male migrate in search of work to different other districts as well as another country.

Health Financing

In the consecutive fiscal years 2080/81 and 2081/82, Panchadewal Binayak Municipality demonstrated a strong and evolving commitment to health sector development. Even though the municipality's total budget declined from approximately 600,593,057(60 crore 5 lakh 93 thousand and fifty-seven) in FY 2080/81 to around Rs.546, 050,000 (fifty-four crore sixty lakh and 50 thousand) in FY 2081/82, the health budget increased from about Rs.7,31,72,000 to Rs.7,42,42,000, increasing its proportionate percentage from 12.18% to 13.60%, indicating that health sector was given marginally higher priority despite overall fiscal tightening.

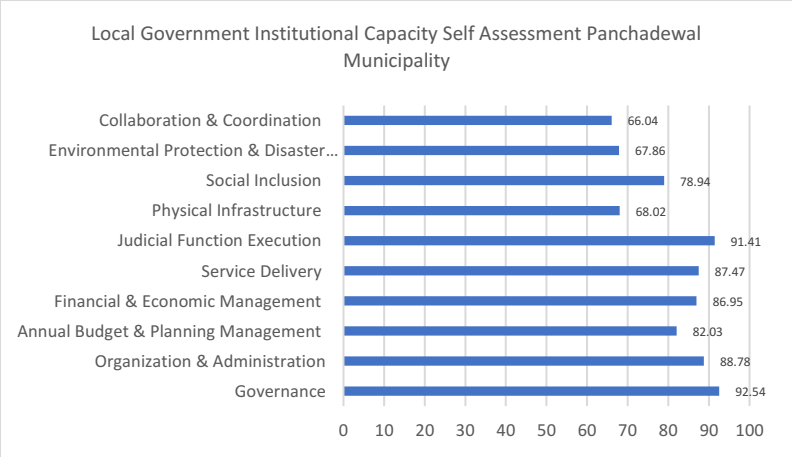
In the fiscal year 2080/81 the budget primarily supported staff incentives, social security schemes, contract service fees, and medicine procurement—focusing on strengthening core service delivery and administrative functions. In the subsequent year the budget was further diversified to include infrastructure upgrades, maternal and neonatal care, nutrition initiatives, and disease control programs. It also emphasized inclusive services, allocating resources for sanitation, public health awareness, and support for marginalized groups such as senior citizens and HIV-positive individuals. This progression highlights a strategic shift from foundational service provision toward more holistic, equity-focused health system strengthening. The observation gets validated during the key informant interview, "the municipality demonstrates responsiveness and sensitivity to health sector priorities, with the fiscal allocation to health considered satisfactory in relation to the overall available budgetary space". The municipality also has adequate human resources as majority of the health institutions have sanctioned positions of the paramedics.

During the sensitization workshop, it was emphasized that the successful operation of the hospital hinges on the federal government's provision of human resources, financial support, and infrastructure. In this context, the Fiscal Commission has, recognized the Municipality for its poor infrastructure set up, low scope for revenue generation and significant economic and social challenges, recommends to allocate highest share of fiscal grants from the central government—80% in complementary grants, that can be taken as an opportunity for infrastructure development including Health, Water Supply and Sanitation.

Governance and Planning

The municipality is participating actively in the overall governance enhancement initiatives of MoFAGA, like LISA and FRA. Beside it has also adopted the approaches to enhance health sector governance through MSS assessment of the Health Posts and management of Health facilities through HFOMCs. It was observed that the municipality is hosting social audit and public hearing on a regular basis. For the grievance handling they have provisioned the complaint box in the municipality and the health facilities, however the practice of lodging complaints was almost non-existent.

Integrating insights from the LISA, the Municipality maintains a strong governance profile with notable performance across all thematic areas. It exceeds district averages in categories such as service delivery, infrastructure, financial management, and annual planning and resource utilization. However, the category of cooperation and coordination slightly trails behind the average, suggesting an opportunity to strengthen multisectoral engagement and inter-agency collaboration. The fiduciary risk assessment score is satisfactory for the municipality.



The municipality exhibits weak planning process, as the seven-step planning process frequently struggles due to high local demands from the settlements and constrained funding, with committees largely focusing on ward-level concerns instead of broader health sector priorities. Capacity gaps persist

as ward chairs and committee members lack clarity on roles. The municipality maintains monthly financial routines and reporting, which support moderate transparency, and achieved a budget absorption rate of 81.35% in 2080/81 that indicates fair utilization. Yet, the predominance of recurrent expenses limits capital budget utilization. Variability in budget allocations across fiscal years and the omission of funds for essential programs in FY 2082/83 expose deficiencies in medium-term planning and strategic foresight.

It has conducted the MSS of all the 9 health facilities in the FY 2081/82, Barala, Toli, and Binayak stood out with the highest overall MSS scores, reflecting strong performance across governance, clinical, and support services. On the other hand, Kuika and Kalekanda scored the lowest, suggesting they may need focused support, especially in clinical and support service management.

Health Posts	Governance & Management	Clinical Service Management	Institutional Support Service Management	Total Score
Kuika	65	60	61	61
Binayak	84	88	81	86
BHSC	84	79	77	80
Kuchhi	74	88	75	85
Layanti	72	77	67	77
Toli	98	88	82	87
Pulletola	89	83	66	81
Barala	94	89	80	88
Kalekanda	80	65	61	67

Table 2: MSS Assessment of Health Post

The OAG audit findings for FY 2080/81 reveal a pattern of prioritizing short-term, small-scale projects over strategic, long-term investments—highlighting a gap in effective planning and institutional vision. Key governance weaknesses include the absence of formal budget execution guidelines and the lack of enacted internal control measures to uphold fiscal discipline. Moreover, issues such as salary disbursements without approved payrolls and the poor performance of internal audits point to weak financial oversight and inadequate accountability mechanisms within the municipal system. A significant surge in capital expenditure—67.95% in the final quarter and over half in the month of Asar—reflects poor procurement planning and last-minute implementation. Financial oversight remains compromised, with NPR 10.3 crore in cumulative irregularities. Asset management is also inadequate due to partial adoption of the Public Asset Management System (PAMS), with gaps in inventory control and disposal protocols. In the health sector, unjustified field allowances were issued without regulatory basis, medicine procurement lacked expiry tracking and stock verification, and the hospital construction project faced delays from unresolved land issues, resulting in an unaccountable 18-month timeline extension.

Coordination and Collaboration

The municipality acknowledges weak coordination, both across government levels and among neighboring municipalities. For the internal coordination viz municipal level coordination also there's no established Multi-Sectoral Coordination Committee, leading to fragmentation in health planning and response. Collaboration remains limited to a small three-member Social Development Committee that convenes only during budgeting and the municipal health section, offering no broader platform for intersectoral action. This parallels national findings that intersectoral coordination in Nepal's Municipal Health System is minimal, constraining efforts on health development. During the Nepalgunj workshop, the Municipality acknowledged and endorsed the proposed structure and accompanying terms of reference. A unanimous decision was made to move forward with the establishment and operationalization of the entity in the coming days.

Key Issues and Challenges:

- Operation of Basic Health Service Hospital bearing the fiscal responsibility of the HR salaries might constraint the municipal fiscal basket.
- Municipality may not be able to construct all the health facilities as per the national standard without provincial and federal support.
- Municipality have not developed the local level health specific laws, strategies hindering effective health program development and improved health governance. The reason behind this is due to limited availability of legal experts and technical support.
- Some components of BHS like NCD, Mental Health, Ayurveda and Geriatric services needs to be developed more.

- Federal funding for provisioning of round the year availability of medicine is not sufficient and the municipality is allocating additional budget to bridge the gap.
- Supply of medicines and commodities (Family Planning) supply from Province used to get disrupted for certain period of time hindering the delivery of BHS
- While Panchadewal has made strides in facility expansion, many health posts still lack diagnostic equipment, essential medicines, and adequate sanitation
- Municipality also have to respond to the specialist health care needs of the people.
- Municipal financing is scattered on short-term small projects rather than strategic long-term projects reveals a lack of effective Strategic planning and vision.
- OAG has highlighted, expenditure without development of required procedures and lack of financial control guidelines impacting fiscal governance.
- The seven-step planning process frequently struggles due to high local demands and constrained funding.
- Sustainable operation of health services even for basic care depends heavily on intergovernmental fiscal transfers.
- Sectoral silos persist between health, education, and social sectors, limiting joint planning and resource pooling. There is no functional multi-sectoral coordination committee.
- Health facility operation and management committees (HFOMCs) are underutilized, and citizen feedback mechanisms are weak or absent except for public hearing and social audit.

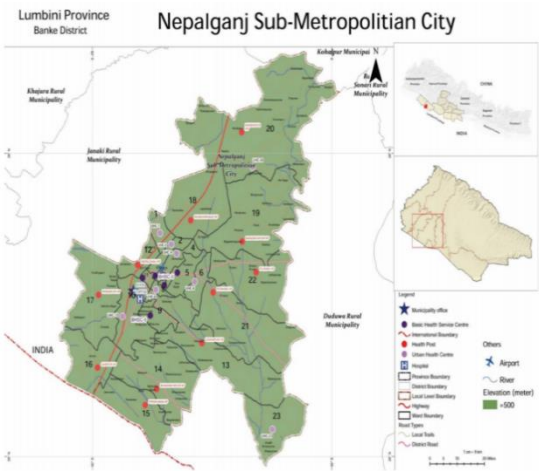
Recommendation for Improvement.

- Develop adequate policy environment by developing the relevant health acts, regulations, strategic plan, guidelines and other procedures with assistance from support partners GiZ and MuAN.
- Implementation of the program by developing the program implementation guideline and procedures.
- Strengthen coordination with province/federal level entities for timely supply of FP and nutrition commodities.
- Embed NCD and mental health screening and counseling into routine health service delivery or systematic community outreach services.
- Promote and integrate Ayurveda services through awareness and outreach.
- Shift from fragmented small projects to long-term strategic planning, through development and implementation of five-year strategic plan for Health.
- Strengthen financial control systems payroll approval, audits, and expenditure tracking.
- Build capacity of ward and municipal teams on the 7-step planning process.
- Prioritize the operationalization of its Multisectoral Health Coordination Committee (MHCC) by finalizing Terms of Reference (ToR) that reflect local needs and ensure inclusive representation of relevant stakeholders/sectors. Regular quarterly meetings should be institutionalized, with clear action tracking mechanisms and public sharing of decisions to promote transparency and accountability.
- Expand MSS in other facilities also, GiZ might support in customizing it for the same.
- Foster stronger coordination and collaboration with development partners (e.g., GIZ).

Section 2: Nepalgunj Sub-Metropolitan

Background Features

Nepalgunj Sub-Metropolitan City, situated in Banke district of Lumbini Province, is one of western Nepal's most prominent and rapidly evolving urban centers. Spanning an area of 85.94 square kilometers and divided into 23 administrative wards, Nepalgunj is home to a population of 164,444 people, with 82,755 males and 81,689 females as per the 2021 census. Nepalgunj is known for its religious diversity. Hinduism is the dominant religion, with 70.0% of the population identifying as Hindu. Muslims make up 27.8% of the population. There are also smaller populations of Buddhists, Christians, and followers of other religions. The city has a high population density of approximately 1,913 people per square kilometer, reflecting its growing urban character. People from neighboring hill districts like Surkhet, Dailekh, and Jajarkot especially in search of better employment, healthcare, education, and urban amenities come here.



While Nepalgunj receives significant in-migration, it also sees a steady outflow of youth and working-age population to India and Gulf countries for foreign employment. The city's demographic profile includes 6,343 children under the age of five and 3,896 infants under one, showing signs of a youthful population, though the Total Fertility Rate (TFR) in line with Lumbini Province is declining to around 2.2 children per woman. Public mobility in Nepalgunj is supported by a variety of transport options, including city buses, e-rickshaws, and even air travel making service delivery faster and more accessible. As a healthcare hub for nearby, the city relies heavily on ambulance services for emergencies, maternal care, and chronic illness management.

Situation Analysis

The situational analysis evaluates the municipality's progress and performance across key health system building blocks. These include Health Infrastructure and Human Resources; the Policy Environment; Delivery of Basic Health Services; Health Financing; Governance and Planning; and Coordination and Collaboration.

Health Infrastructure and Human Resource

There are currently a total of 27 public health institutions, including 11 health posts, 5 basic health service centers, 6 urban health centers, 1 urban health promotion center, 1 Ayurveda health center, and 3 Ayurveda dispensaries run by the metropolitan. Besides as a provincial hub, there are 3 government hospitals and 15 private hospitals. There are 29 DOTS centers (for TB treatment), 23 CB-PMTCT sites, 6 adolescent friendly sites, 5 birthing centers, 2 safe abortion (MA) sites. Municipality also has 1 operational laboratory, PMTCT, HIV testing and counseling (HTC) services sites and 1 health desk POES (Point of entry service). Twenty one of the 23 health institutions have buildings that meet the national building standards. There are 81 vaccination centers (only 27 with their own buildings), 30 outreach clinics (none with their own building).

In Nepalgunj, there are a total of 72 sanctioned positions in 11 HPs and a team of 11 people working at the Municipal office, all of which are filled. However, other health facilities including 1 UHPC, 11 BHSC have no sanctioned positions. Municipality has done organization and management survey and this has not been endorsed by the Federal Government hence, staffs in these facilities are recruited on contractual basis and utilizing the municipal resources. So, a total of 56 staff are working on a contract basis and 181 FCHVs are currently working in the Municipality. To complement the HR need in overloaded birthing center of ward number 20, Provincial Government has deputed two nurses. "The health sector resource of the municipality is largely drained in managing HR of the 13 wards where HFs do not have sanctioned positions, to mitigate this municipality did the O&M survey but unless and until it gets endorsed by the federal government, the municipality will not be getting resources even for catering BHS from these sites. Provisioning of BHS, though is the mandate of the municipality but is also an obligation of federal government under the fundamental right as per the clause 35 of the constitution so support from federal government is critical."

> *"In certain wards, health facilities are located within close proximity—often just a 5 to 10-minute walk apart. A proposal was introduced to merge these facilities to enhance efficiency in human resource utilization, infrastructure management, and overall service delivery. However, the initiative was not implemented due to opposition from the ward chair, who did not support the idea"*
> Health Worker during KII

Health Policy Environment

As per the municipal presentation in sensitization workshop as well as from scan of Municipal web page the total of 41 legal and regulatory instruments has been developed but the policy instruments regarding health were only five. The five health related Acts, guidelines and procedures developed by the municipality are:

- Health Policy 2076
- Directive on Establishment, Operation, and Renewal of Health Institutions, 2076
- Health Services Act, 2079
- Sanitary -pad procurement standard 2081
- Nepalgunj Sub-Metropolitan city's Health Program Operation Directive 2081/082

Table 3: Legal Instruments Developed at Nepalgunj Sub metropolitan

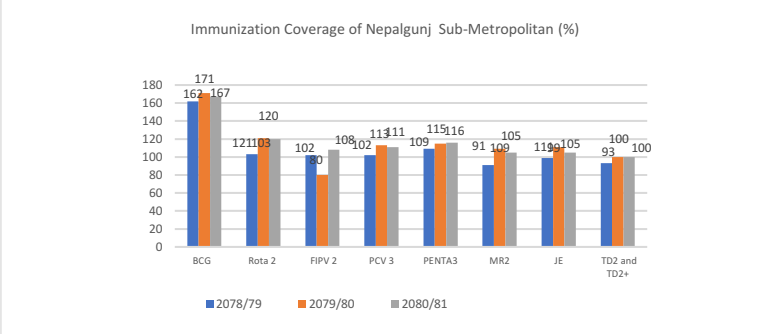
S. no	Municipalities	Act	Regulation	Guidelines/ procedure	Standard / code of conduct	Periodic plan	total	Health Related
1	Nepalgunj Sub metropolitan city	7	2	26	2	4	41	5

Basic Health Services Delivery

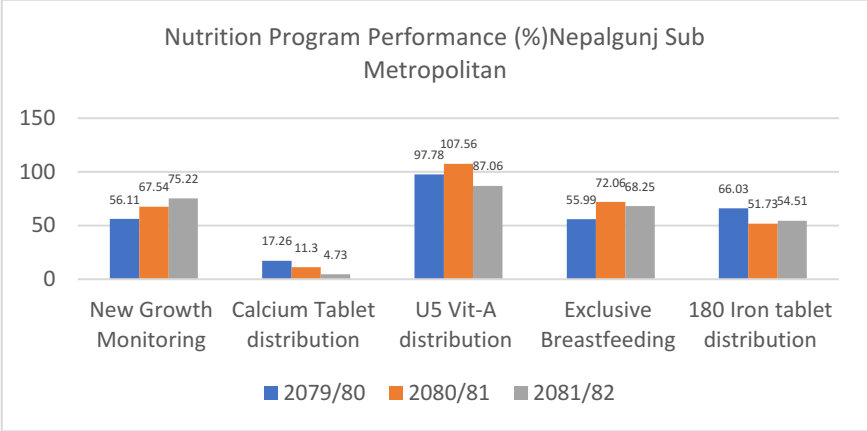
The Basic health service has been catered through a total of 27 public health institutions, including 11 health posts, 5 basic health service centers, 6 urban health centers, 1 urban health promotion center, 1 Ayurveda health center, and 3 Ayurveda dispensaries. There are no basic hospitals, primary health centers, community health units. Regarding the delivery of BHS services all the services offered through the HFs are free to the people. However, as per the elected representative, "the same is not true at the hospitals, people are paying for services" which is also evidenced in DHS further analysis report no 158 as the BHS services are largely free at municipality level but people are paying at federal and provincial hospital. Beyond basic health service which has not been catered but that was needed in community to be catered by a specialist doctor could be possible only when a specialist cadre is provisioned at the local level, this was repeatedly demanded by the Deputy Mayor during the sensitization workshop.

As per the available information presented during the sensitization workshop and annual report of the 2080/81 of the municipality some service delivery components are elaborated below;

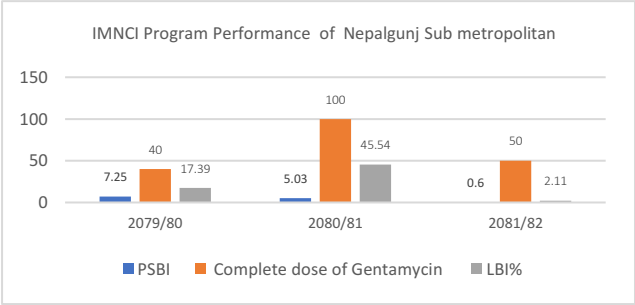
In **Immunization** Nepalgunj Municipality, reveals consistently high rates—often exceeding 100%—across several antigens such as BCG, PCV, and MR. This unusually high coverage is likely due to the influx of populations from neighboring provinces like Karnali and the Far Western, whose children are vaccinated in Nepalgunj but not reflected in the official target population, thereby inflating the figures. However, these numbers may camouflage underlying vulnerabilities, as measles outbreaks have recurred despite the reported coverage. This discrepancy has been realized by the municipality and full immunization declaration initiative is being implemented to validate actual reach and strengthen accountability. Additionally, municipality has identified and prioritized hard-to-reach areas to ensure equitable coverage and prevent future outbreaks, especially in marginalized or mobile populations.



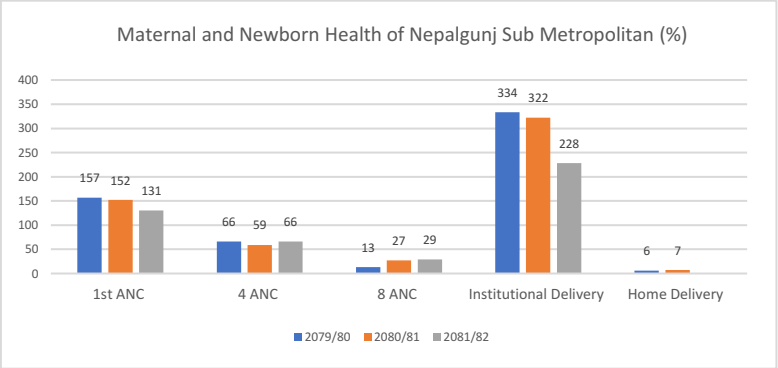
In **nutrition service**, the new growth Monitoring rate was increased to 75.22% in the FY 2081/82 whereas, exclusive breastfeeding in the municipality decreased from 72.06% to 68.25% in 2081/82, while district shows a slight increment in exclusive breastfeeding. Iron tablet distribution slightly increased seen in 2081/82 but still less than 60 percent women have been reached so far. Vitamin A coverage has decreased gradually from previous year from 107 % in 2080/81 to 87.06% in 2081/82 in municipality level whereas the same is reported to be increased in district level. Calcium tablet distribution was a local initiative but the coverage of it is below five percent and is on consistent decrease over the years.

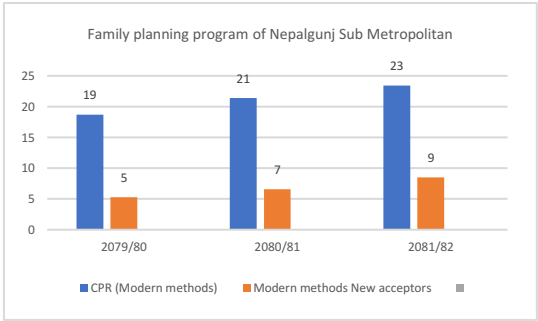


Child health services are provided free of charge. The prevalence of Severe Bacterial Infection (PSBI) has declined to 0.65% in 2081/82. Pneumonia cases increased to 38% in 2080/2081 while district also reported the increment rate. Though no cases of diarrheal death observed and only one severe diarrhea case was reported in three consecutive fiscal years, incidence was reported high (400/1000U5Children) in the year 2081/82.



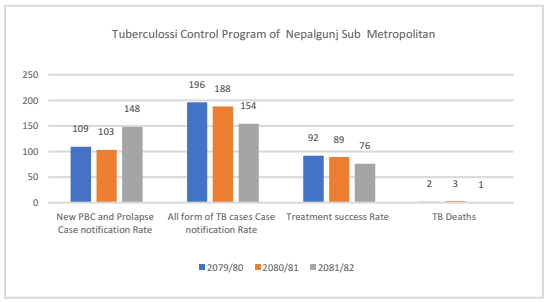
Regarding **maternal health services**, there are 5 metropolitan run birthing centers where maternal health services are free for the people besides several other public and private health facilities offering free delivery services. Four ANC visits coverage slightly increased to 66% from previous year, in congruence with the Banke district's increment and is above the nationally identified 50% coverage from the DHS 2022. In contrast, ANC 8 visits increased slightly in the municipality to 29% from previous year. Institutional deliveries was declined but like immunization it is still well above 100 percent in FY 2081/82. Home delivery was increasing from 2079/80 to 2080/81. Delivery done by SBA decline from previous year which was also seen in district level. Low birth weight cases declined to 14.9% in 2080/81. Maternal death and neonatal deaths has gradually decreased as compared to the previous years. Safe abortions were done surgically under 12 weeks, especially among women aged ≥20 (978 cases) compared to <20 (46 cases). Post-abortion, short-term contraceptives were much more used (402) than long-term (65). A notable 66 cases of complications highlight the need for improved post-abortion care. As a growing problem the metropolitan has observed that home delivery is gaining popularity, many people wish to deliver at home, bringing the service providers to their home offering a handsome fee ranging from 10000 to 60000 NPR. Nepalgunj Metropolitan is one of the municipalities with highest maternal mortality in the Nepal and the reported maternal death review revealed that all the women who died were never came into the system's care continuum until the complications was severe. All such deaths have occurred in the health facility, often received so late that limited space for interventions are left.





In **Family planning** municipal data shows that the number of new users of modern contraceptives has increased from previous year to 8.5% in FY 2081/82, which is congruent with Banke district's increment. CPR among has increased gradually from 19 percent from the FY 2078/79 to 23 percent in 2081/82 is very less with compared to the national figure reported in 2022 DHS survey.

Regarding services related to **Infectious disease**, TB cases notification rate of all form of Tb cases declined from 196 to 154 in the FY 2079/80 to 2081/82 and the treatment success rate also seem to decline. Leprosy new cases in the municipality showed a slight increase, similar to trends in Banke district, where scattered new cases persist posing challenge in achieving the sub national elimination target. HIV/AIDS new cases in the municipality showed a slight decline whereas total number of cases of HIV showed increment gradually from FY2078/79 to FY 2080/81. Increase percentage of pregnant mothers (435%) were tested for HIV in the FY 2080/81. Malaria positive cases are increasing in the municipality in the recent year.



Among the NCDs, Hypertension stands out as the most prevalent condition, with 1,659 cases, followed by Diabetes at 538, Asthma at 306, and COPD at 240 in the fiscal year 2080/81. Alcohol-related liver disease is notably rare, with only a single reported case. The stark disparity in case numbers suggests that cardiovascular and metabolic conditions dominate the local NCD landscape, potentially reflecting lifestyle patterns, aging demographics, and gaps in preventive care. Among the mental illness the only 3 cases of anxiety disorder were reported in the fiscal year 2080/81. As several hospitals both private and public do not record the services offered in the out patients thus the real picture of the

NCD burden is not reflected in municipal analysis but the observation shows very high number of NCDs throughout the metropolitan.

Health Financing

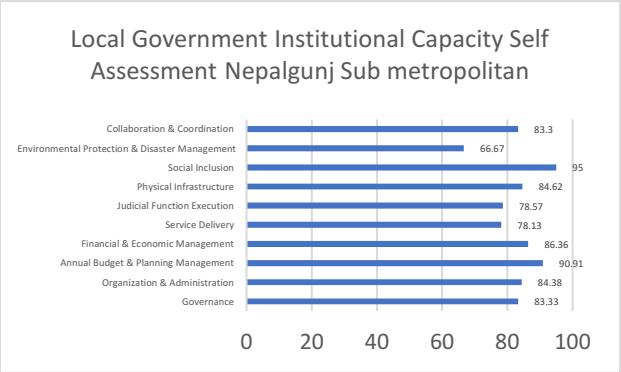
Nepalgunj Sub-Metropolitan City has been recognized by the National Natural Resources and Fiscal Commission as one of the more financially self-reliant municipalities in Nepal, with robust infrastructure, vibrant economic activities, and strong revenue generation capacity. Due to this relative fiscal strength, Nepalgunj is eligible to receive only 30% in complementary grants—the second lowest share among the seven categories.

Both the federal contribution as conditional grant is also shrinking together with the decrease in the municipal allocation to health in past three consecutive years. In FY 2080/81, Nepalgunj Sub-Metropolitan City had a total budget of NPR 1,834,057,445 with approximately 7.7 percent allocated to the health sector claimed to be significantly lower than allocations in many rural municipalities. As flagged in the KII, most of the health sector budget are being expended in the salary of the HR and significant proportion 30-35 lacs goes to the medicine procurement and 15-20 lakhs for NGO implemented programs. So, after deducing the HR costs the health sector allocation comes to be around 1.4% only. Thus minimal funds are left for critical programs, such as NPR 1 lakh for disease control and just NPR 50,000 for family planning, underscoring the need for better financial prioritization, procurement systems, and long-term strategic planning.

Governance and Planning

In Nepalgunj Sub-Metropolitan City, the seven-step local planning process reflects both strengths and gaps. As the municipality lacks sectoral plans, long term plans, OAG has flagged that the planning is rather distributive. However, municipality have developed the health policy back in 2076 which guides with defined health priorities. The planning process often lacks meaningful participation of the stakeholders however in this year's budget planning the health section attempted to host a planning workshop involving all the health facility in-charges. More needs to be done to foster evidence-based planning. The metropolitan has attempted to allocating funds from FY 2083 onwards for mothers' group meetings as per the contextual need and demand from the FCHVs.

The sub-metropolitan is participating actively in the overall governance enhancement initiatives of MoFAGA, and have participated actively in assessments like LISA, FRA. Besides it has also adopted the approaches to enhance health sector governance through MSS assessment of the Health Posts and management of Health facilities through HFOMCs. It was observed that the municipality is hosting social audit and public hearing on a regular basis. For the grievance handling they have provisioned the complaint box and it had also created a digital web-based application to lodge the complaints which can be seen in its website, however during the interview officials informed that the practice of lodging complaints was almost non-existent.



The self-assessment of institutional capacity in Nepalgunj Sub-metropolitan reveals a generally strong performance with an aggregate score of 83.3%. It has standout scores in Social Inclusion and Annual Budget & Planning (both at 90), suggesting robust mechanisms for equity and fiscal planning. Governance, Organization & Administration, and Financial & Economic Management also score consistently high (83.33), indicating solid foundational structures. However, Environmental Protection & Disaster and Physical Infrastructure lag behind at 66.67, pointing to critical gaps in resilience and infrastructure development. These disparities underscore the need for targeted interventions in environmental preparedness and infrastructure investment, while leveraging strengths in planning and inclusion to drive holistic improvements. In the fiduciary risk assessment front it has scored 86.5 percent in gross and has risk in

procedural, outcome and fiscal discipline is 88, 84 to 83 percentages respectively. It has scored less than 80 percentage in revenue management, underscoring improvement.

As MSS assessment was done for 11 HP only in the FY 2081/82. In FY 2080/81**,** Udaypur Health Post achieved the highest overall HP-MSS score (80), performing strongly across all three sections while the lowest score was recorded at Basudevpur Health Post (61). Three HP are securing score below 70 percent underscoring the improvement. Among the three areas of evaluation greater improvements are needed in clinical service management domain. During the assessment it was identified that HFOMC committee members have not been oriented well about the TOR and monthly meeting shall be regularized. In the clinical service domain, waste segregation, establishment of breastfeeding space and enhancement of activities of infection prevention were identified as areas of improvement.

Name of Health Post	Governance & Management	Clinical Service Management	Support Service Management	Total Score
Nepalgunj Health Post	84	65	68	70
Udaypur Health Post	94	73	87	80
Bhawaniyapur Health Post	80	67	77	72
Piprahawa Health Post	82	62	61	66
Jaispur Health Post	82	63	75	69
Parsapur Health Post	71	58	68	63
Khaskarkado Health Post	82	64	82	71
Basudevpur Health Post	72	56	62	61
Manikapur Health Post	87	69	80	75
Puraina Health Post	68	58	68	62
Puraini Health Post	78	62	75	68

Table 4: MSS Assessment of Nepalgunj sub metropolitan

Coordination and Collaboration

Nepalgunj Sub-Metropolitan City has institutionalized health-sectoral coordination by enacting it into law to promote structured collaboration among multisector stakeholder engagement. However, the health section officer noted “that although the legal framework exists, regular meetings are not being held, and the coordination committee remains largely inactive”. After review of the proposed structures and TOR during the sensitization workshop, the metropolitan has agreed to reform making it more inclusive and also broadening the TOR of the committee.

Key Issues and Challenges:

- Despite the constitutional guarantee of free basic health services, out-of-pocket payments continue, especially in hospitals, and stock-outs of essential medicines, vaccines, and FP commodities disrupt consistent service delivery.
- Metropolitan run health facilities are under-equipped and understaffed, leading to overcrowding at central institutions, some health posts still operate from temporary or rented buildings.
- Mental health, NCDs, and geriatric services are poorly integrated into primary care, with limited data, low awareness, and underutilized service platforms. Diagnostic services (e.g., USG, NCD labs) and specialist care are largely unavailable at municipal health facilities, limiting early detection and comprehensive treatment for NCDs, mental health and others.
- Maternal and child health services suffer from low ANC 8 coverage, a growing trend of home deliveries (including paid home-based services), and preventable maternal deaths linked to late care-seeking.
- High coverages in immunization and ANC and institutional deliveries have been camouflaged by the influx of the people from other districts in search of medical care, so increase community mobilization is very critical to know the exact situation and also the catch the missed opportunities. Mothers group activation and FCHVs mobilization needs acceleration.
- Health financing is sub-optimal, with most of the health budget consumed by staff salaries, leaving minimal room for programs, medicines, and community outreach.
- Local health policies and guidelines are either missing or outdated, while the 7-step planning process is often bypassed or repeated without real-time needs assessments.
- Programmatic budgeting and implementation lack flexibility and evidence-based prioritization; annual guidelines are poorly executed, and audit irregularities remain unaddressed.

- The multisectoral coordination committee is non-functional, so ample opportunities exist for integration between health, WASH, environment, and education sectors initiatives for mutual gain.
- Rapid urbanization, environmental pollution, industrial hazards, road accidents, and weak community engagement are escalating urban health risks, while municipal capacity for emergency response and environmental health management remains limited.
- Possibilities of efficient operation of the health facilities has not been explored to the fullest like merging of the health facilities is possible in several wards as HFs are being operated with 10 minutes walking distances.

Recommendation for Improvement.

- Advocate and ensure constitutionally mandated BHS services are provided free from the hospitals.
- Improve the supply chain management to unsure consistent BHS service delivery and advocate to authorize municipalities to procure all the medicines needed for BHS delivery.
- Advocate for increase investment in infrastructure and HR provisioning from the federal and provincial government.
- Upgrading infrastructure and equipping peripheral health facilities to reduce overcrowding at central institutions, and phase out rented spaces by constructing permanent infrastructures.
- Integrate mental health, NCDs, geriatric, and disability-inclusive services into the municipal health care delivery system through regular screening, service documentation, and staff training, and ensure deployment of diagnostic services such as USG and NCD labs.
- Strengthen maternal and child health services by expanding ANC outreach, enhancing referral systems, and discouraging unsafe home deliveries through better regulation and incentives for institutional care.
- Reactivate and mobilize mothers' groups and FCHVs to increase community participation, generate demand, and identify missed beneficiaries, especially in light of high population influx from neighboring districts.
- Increase the health budget allocation for programmatic activities, community mobilization, medicine procurement, and outreach—beyond just covering staff salaries.
- Update and implement local health policies and procedures aligned with national standards, and strengthen the participatory 7-step planning process to reflect current health priorities and community needs.
- Improve budget execution and financial accountability by separating salary and programmatic costs, ensuring evidence-based budgeting, tracking expenditures in real-time, and addressing audit findings through internal controls.
- Re-activate the Multisectoral Health Coordination Committee (MHCC) with regular meetings, clearly defined TORs, and integrated planning across WASH, education, and environment sectors.
- Enhance urban health resilience by integrating emergency preparedness into municipal planning, strengthening solid waste and pollution control systems, and promoting community-based risk reduction.
- Explore rationalization of health facilities by conducting a geospatial mapping and efficiency audit to consider merging closely located facilities, improving HR distribution, service integration, and operational efficiency.

Section 3: Triveni Municipality

Background Features

Triveni Municipality, lies in the hills of Bajura district in Nepal's Sudurpaschim Province, covering about 170 square kilometers, this rural municipality stretches across 9 wards. The municipality is a home to a population of 17463 across 3350 households with a population density of 104 people per square kilometer. There are around 2,735 children under 5. Socially, Triveni reflects the diversity and complexity of Nepal's caste and ethnic fabric. A significant portion of its residents are from marginalized communities, including Kami (11.2%), Sarki (6.3%), and Badi (3.9%), and others (11.7%). There are also over 1,400 people with disabilities in the municipality, ranging from physical impairments to visual, hearing, and intellectual challenges. Geographically, Triveni is rugged and remote. A handful of rough roads allow motorcycles and jeeps to access some areas, but in many wards, travel is still on foot or by mule. This severely affects health and education service delivery, especially during emergencies or the rainy season. One of the most defining trends in Triveni is out-migration.

Situation Analysis:

The situational analysis evaluates the municipality's progress and performance across key health system building blocks. These include Health Infrastructure and Human Resources; the Policy Environment; Delivery of Basic Health Services; Health Financing; Governance and Planning; and Multisectoral Coordination and Collaboration.

Health Infrastructure and Human Resource:

There are 3 health posts and 7 basic health service centers, along with 2 Urban Health Centers (UHCs). Immunization services are provisioned through 11 immunization clinics and 12 birthing centers are operational. In four health facilities laboratory services are also available. However, advanced facilities like BEONC, CEONC, Gene-Xpert, DR, HTC, ART, and CD4 centers, as well as NRH, are all absent. Additionally, there are 27 female community health volunteers supporting health services. No PHC/ORC clinics in the municipality.

> *"Municipalities like Triveni, without the support of Federal or Provincial Government cannot finance the operation of Hospital"*
>
> -Municipality Official

There are 18 sanctioned health positions, with 11 filled and 7 vacant, plus 32 paramedics are working on contract-based roles. As per CAO, hospital establishment initiative is pending due to dispute between a health post and the municipality over the location of establishment and is under consideration in Supreme court. He has also highlighted an issue that only three HPs have the sanctioned positions while all other HFs have no sanctioned position and as per the federal governments guidance to have health facility in each ward BHSC and UHC are operational with birthing centers in many and the HR are being recruited on contractual basis. A recent legal restriction from provincial government has created an environment to refrain from recruiting which might impact service delivery. Besides, O&M survey has been done by the municipality which is pending approval from the Federal government, in absence of these OAG will continually consider their salaries as ineligible expenses and volume of irregularities will continue to increase. This has created an awkward situation which needs to be resolved and MuAN and GiZ are expected to advocate for this situation.

Health Policy and Legal Frameworks

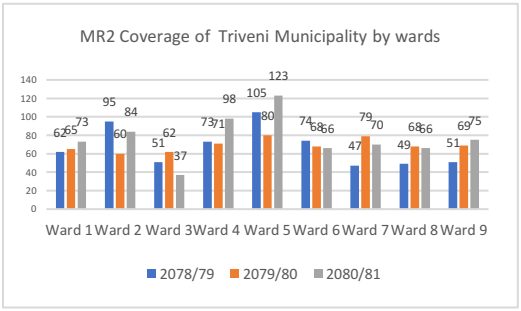
Scan of the municipal web page and municipal presentation shows that a total of 64 legal and regulatory instruments have been developed but the policy instruments regarding health are none. CAO has reconfirmed that the municipality rely on the provincial and federal policy instruments. They have anticipated the support of GiZ and MuAN in developing the relevant policy instruments.

Table 5: Legal Instruments Developed at Triveni Municipality

S. no	Municipalities	Act	Regulation	Guidelines/ procedure and directives	Standard / code of conduct	Periodic plan	Total Policy Instruments	Health Related
1	Triveni Municipality	14	4	41	4	1	64	0

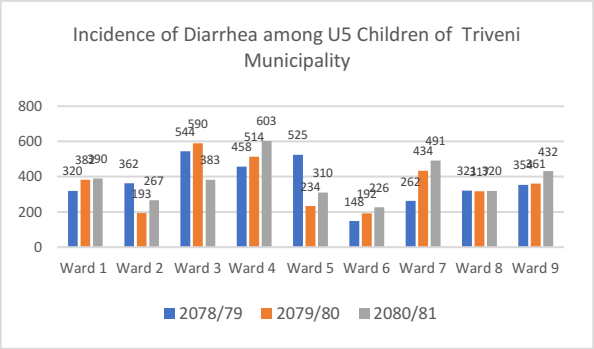
Basic Health Service Delivery:

All the nine components of the Basic health service have been catered through 12 basic health facilities, including HP, BHSC, CHU and UHC. There are no basic hospitals, private or non-governmental health institutions, or central-level health facilities functional within the area. Regarding the delivery of BHS services all the services offered through the HFs are free to the people. Beyond basic health services has also been catered through Rural Obstetric Ultrasound (ROUSG) program, cervical cancer screening, obstetric fistula detection, and pelvic organ prolapse management program. Service delivery status as evidence through DHIS 2 information management system have been analyzed below:

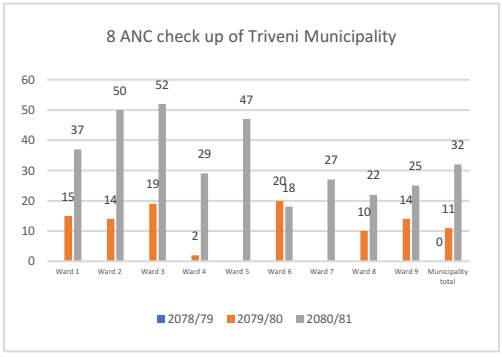


The **immunization coverage** among children under one year has shown a consistent decline over the past three fiscal years. Specifically, BCG coverage dropped significantly from 83% in FY 2078/79 to just 61% in FY 2080/81. Similarly, the coverage for the DPT-HepB-Hib3 vaccine also declined from 80% to 66% during the same period. Measles and Rubella (MR) vaccines typically has increased as comparatively where Ward 5 had the highest whereas Ward 3 had the lowest in FY 2080/81.Other vaccines such as fIPV2, OPV3, PCV3, JE, and Rota have all shown a declining trend, indicating a broader challenge in maintaining immunization coverage. The only exception after MR2 is the typhoid vaccine, which has seen an encouraging rise from just 15% in FY 2078/79 to 75% in FY 2080/81. According to the DHS 2022 report, national immunization coverage remains a concern, with full immunization coverage at 79%, and significant gaps in timely and complete vaccination. This underlines the urgent need for focused interventions to strengthen routine immunization services at the local level.

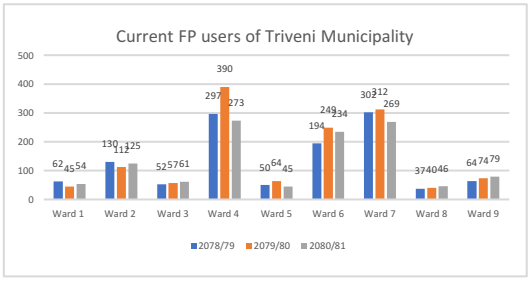
In **Nutrition status** from FY 2078/79 to 2080/81, the number of SAM (Severe Acute Malnutrition) cases admitted to outpatient therapeutic centers decreased steadily from 35 to 16. Vitamin A supplementation coverage among children aged 6-59 months fluctuated but improved overall, rising to 93% in 2080/81 which as per DHS 2022 report, nationally is just 71%. For postpartum women, Vitamin A supplementation consistently achieved full coverage (100%) in the following two years. Iron supplementation showed a decline with only 49% of pregnant women received the recommended 180-day supply of Iron Folic Acid in 2080/81 whereas according to the DHS 2022 report, nationally only 44% of pregnant women complete the full iron folic acid regimen. These trends highlight progress in some nutrition services but underscore the urgent need to strengthen iron supplementation programs during pregnancy.



Child health (IMNCI) services are provided free of charge. IMNCI services for children under five have shown improvement in utilization, with the number of children served increasing from 1,005 per thousand in 2078/79 to 1,433 per thousand in 2080/81. The application of Chlorhexidine gel immediately after birth remained consistently high, nearly 100% each year. Treatment for diarrhea with zinc and ORS, as well as pneumonia with antibiotics, has been consistently at 100% throughout these years. However, Kangaroo Mother Care (KMC) for preterm or low birth weight newborns was not provided in any year. The administration of the first dose of Gentamicin to infants with PSBI dropped to 0% in 2079/80 but rebounded back to 100% in 2080/81, indicating a temporary gap in service delivery. Additionally, the highest incidence of diarrhea over the two years was reported in ward 4, while ward 6 recorded the lowest incidence. According to DHS 2022, nationally, care-seeking for childhood illnesses like diarrhea and pneumonia remains below 70%, with gaps in KMC implementation and antibiotic treatment, underscoring ongoing challenges in child health service delivery despite improvements in some areas.



Regarding **maternal health services**, there are 9 birthing center where maternal health services are free. Four ANC checkups declined steadily from 76% to 54%, while eight ANC visits increased significantly from 0% to 32%, with the highest coverage in Ward 3 and Ward 2 in 2080/81, and the lowest in Ward 6. Institutional deliveries dropped by 9 %from 62% to 53%, though Ward 2 maintained the highest institutional delivery rate in both 2079/80 and 2080/81, while Ward 8 recorded the lowest in 2080/81. Postnatal care improved, with 4 PNC visits rising from 0% to 50%. HIV testing among pregnant women were also reported increased. Medically induced abortions increased, while surgical procedures remained at 0% throughout. According to DHS 2022, nationally about 69% of women complete four ANC visits, 77% deliver in health facilities, and postnatal care coverage is improving, indicating that although the municipality is progressing, maternal health service utilization still lags behind national averages.



Family planning data shows minimal change in new users of modern contraceptives, decrease with 15% in 2080/81. In FY 2080/81, Ward 4 had the highest and Ward 5 the lowest number of new users in year 2080/81. The Contraceptive Prevalence Rate remained mostly stagnant, dropping slightly from 32% to 31% which is almost 12 % less that the national CPR as per DHS 2022.

Service related to **infectious disease**; HIV testing increased from 39 to 115 over three years. The number of people living with HIV slightly declined. TB notification showed minor fluctuation, while the treatment success rate dropped and remained low at 69%, whereas nationally it was around 85% as per DHS 2022. No cases of drug-resistant TB, leprosy, or kala-azar were reported during the period. From 2078/79 to 2080/81, URTI cases increased steadily. Mumps cases increased in 2080/81. Dengue, measles, and AES cases appeared only in 2080/81.

According to CAO, "services related to **non-communicable disease**, Hypertension and diabetes cases show a clear rise over the years though they are not among the top ten diseases'. COPD cases increased sharply in 2079/80 but then

declined in 2080/81. No cases were reported for cancer and RTA. These trends emphasize the urgent need for enhanced local screening, management, and prevention programs to address chronic health conditions effectively. Services related to mental health illness as cases were low overall, Depression was seen in the recent years with total 2 cases in 2080/81. Anxiety disorder appeared only once in 2079/80. No cases of conversion disorder or acute psychosis were reported in any year.

For the delivery of the health services, many health facilities lack basic equipment and furniture but this has to be assessed systematically through need assessment and during the KII the municipality official anticipated the support in this regard from the GiZ. Capacity enhancement of the health worker and HFOMC members and ward chairs is another area where the municipality seeks support.

Health Financing

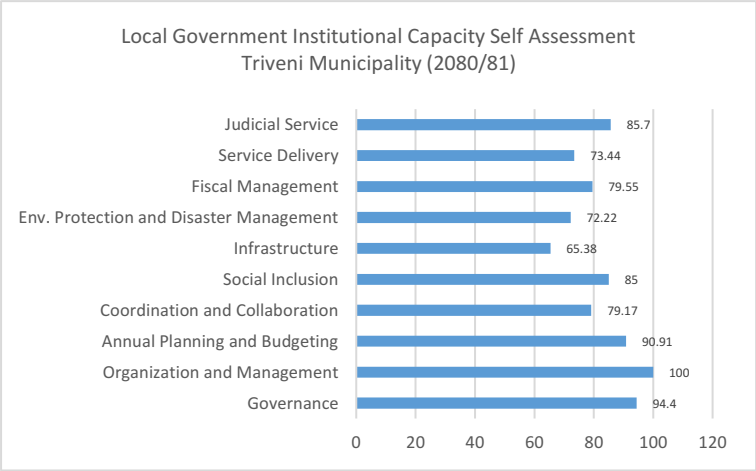
In fiscal year 2080/81, Triveni Municipality allocated a total budget of approximately NPR 458 million, with health sector spending amounting to around NPR 96 million—roughly 21% of the total budget. In 2081/82, the total municipal budget increased to about NPR 478 million, while health sector allocations rose to approximately NPR 99 million, maintaining a similar proportion of 20.7%.

The medicine procurement budget ranged between NPR 1.0- 1.5 million, while support for institutional delivery and emergency referrals was consistently maintained. However, laboratory services were discontinued in 2081/82. Spending was delayed, with most expenditures concentrated at the end of the fiscal year, and the overall absorption rate stood at 85.4%. Despite rising overall budgets, equalization grant allocations to health declined from 2.85% to below 2.72%. Conditional grants showed temporary improvement, reaching 12.56% in 2081/82, but this was not sustained. These trends highlight weak financial planning, inconsistent prioritization, and the need for more timely and transparent execution to improve health outcome.

The Fiscal Commission has, recognized Triveni for its poor infrastructure set up, low scope for revenue generation and significant economic and social challenges, allocates highest share of fiscal grants from the central government—80% in complementary grants, that can be taken as an opportunity for infrastructure development including Health, Water Supply and Sanitation. During the sensitization workshop, it was emphasized that the successful operation of the basic health services relies on the federal and provincial government's provision of human resources, financial support, and infrastructure. To estimate the volume of equalization grant disbursements recommendations, Natural resource and fiscal commission has been using two indicators immunization coverage and institutional delivery which has reduced the volume considerably to rural municipalities that has very high out migration, and this irrational approach shall be changed, and MuAN is again anticipated to advocate for it.

Governance and Planning

The municipality also adopts and participates in LISA, FRA, MSS evaluations and undertakes social audit and public hearings which helps in improved governance in health service delivery at large. It's institutional self-assessment (LISA) reveals overall notable strengths with a score of 81.25%. However, comparatively lower performance in Infrastructure (65.38) and Environmental Protection and Disaster Management (72.22) points to areas where focused investment and strategic planning are needed to enhance resilience and service reach.



Similarly in FRA analysis of 2080/81, it demonstrates average risk scores around 73.5 percentage with weakness in documentation and reporting (64.7%), revenue management (55.8%), and signaling risks in transparency and financial sustainability. Triveni Municipality also follows the 7-step guidelines procedurally, but it lacks participatory depth, ward-level inputs are frequently sidelined during final consolidation by the Seven-Level Planning while preparing the budget. During needs identification, although ward consultations are conducted, decisions are often shaped by elected officials' interests rather than genuine community inputs, as echoed by the chief administrative officer of health: "planning is mostly budget-driven not based on real needs." As a result, the prioritization process often overlooks critical but less visible areas like adolescent health, mental health, and NCDs, even when resources such as trained personnel are available. Some initiatives like declaration of Triveni as a Fully Institutional Delivery Municipality and ongoing maternal health and psychosocial programs in select health posts are the local initiatives which are successfully implemented. However, other programs remain fragmented or unfunded due to poor integration. Finally, monitoring and evaluation remain weak, as shown by delays in trimester expenditure reporting, poor SUTRA system compliance, and a 6.52% financial irregularity rate flagged by the OAG, indicating deficiencies in internal controls and fiscal discipline. To improve, the municipality must institutionalize participatory planning, ensure alignment with actual community health needs, and build stronger systems for financial tracking and accountability.

In context of providing basic health services, MSS has conducted thorough assessments of all the facilities, which is very commendable. Annual evaluations were carried out across all health facilities, and the status of each facility was clearly documented during these assessments and based on the reports, among the assessed health facilities, Chhatara Health Post and Kailashmadaan Health Post both scored 79%, corresponding to the blue color code (70–85% range) whereas Chhatara A. Health Service Center scored 37%, falling in the White category (<50%).

The CAO also emphasized that proper need assessments are lacking, which results in reactive rather than strategic programming—especially concerning communicable and non-communicable disease management. Despite some progress in maternal health, overall public health planning is hindered by limited technical orientation for elected officials, unclear role clarification, and the absence of a localized health strategy

Coordination and Collaboration

Triveni Municipality like others face significant challenges in multisectoral coordination, particularly due to the absence of a formal Multi-Sectoral Coordination Committee. This lack of a structured body has led to fragmented health planning and poor inter-agency collaboration for health development. As noted by both the CAO and health officers, there is currently no such committee in place, though it is deemed essential for effective advocacy and integrated service delivery. The municipality's own institutional assessments (LISA and FRA) have flagged serious deficiencies in infrastructure, revenue management, and financial accountability, reinforcing the need for improved

coordination. During the Nepalgunj workshop, the Municipality refined the proposed structure and accompanying terms of reference of Multisectoral Health Coordination Committee. A unanimous decision was made to move forward with the establishment and operationalization of the entity in the coming days.

Key Issues and Challenges:

1. **Health Infrastructure and Human Resources**
   - Inadequate health infrastructure and services: Most facilities lack advanced services like BEONC, CEONC, Gene-Xpert, and ART; many operate without proper buildings, essential equipment, or furniture.
   - Severe human resource gaps: Only 3 out of 12 facilities have sanctioned government positions; others rely on contract staff whose recruitment is currently restricted by provincial legal provisions.
   - Unresolved institutional and legal issues: A legal dispute over hospital location is delaying its establishment, and contract staff salaries are flagged as ineligible by OAG, increasing financial audit risks.
   - Mismatch between policy mandates and resource allocation: Federal guidelines require one facility per ward, but no corresponding HR or financial support has been provided, creating operational strain.

2. **Policy Environment**
   - Despite developing 64 municipal legal documents, none are health-related, leaving the municipality entirely dependent on federal and provincial policies without a localized health strategy, policy.

3. **Basic health Service Delivery**
   - Essential maternal, child, and immunization services are underperforming: Immunization coverage is declining; institutional deliveries, ANC visits, and iron supplementation fall below national averages; and Kangaroo Mother Care (KMC) remains unimplemented.
   - Family planning and outreach services are weak: Contraceptive uptake and CPR remain stagnant, with no functional PHC/ORC outreach services to extend care to remote populations.
   - NCD and mental health services are lacking: Laboratory services have been discontinued; mental health care is nearly absent; and NCDs like hypertension and diabetes are rising demanding structured screening or management programs.

4. **Financing**
   - Delayed and inefficient budget execution, with most spending concentrated at the end of the fiscal year and weak financial controls contributing to 6.52% audit-flagged irregularities with no internal control guidelines.
   - Declining proportional investment in health, as the share of equalization grants allocated to the health sector has decreased despite an overall budget increase.
   - Unfavorable grant allocation criteria—reliance on indicators like immunization and institutional delivery disadvantages municipalities like Triveni, affected by high out-migration.
   - Federal and provincial contributions are inadequate, forcing local governments to divert internal funds to maintain essential medicine supplies and HR recruitments.

5. **Governance and Planning**
   - Weak participatory and evidence-based planning, with ward-level inputs often overlooked and politically driven decisions sidelining strategic health priorities like NCDs, adolescent, and mental health.
   - Lack of a localized health strategy and technical capacity, limiting effective prioritization and implementation of health programs, especially among elected representatives.
   - Poor monitoring, reporting, and financial oversight, reflected in delays in expenditure reporting, low SUTRA compliance, and weak documentation and revenue management as indicated by the FRA.

6. **Coordination and collaboration**

- Lack of a functional Multisectoral Coordination Committee has led to poor intersectoral collaboration, resulting in fragmented planning, program gaps, and weak performance in infrastructure and disaster management.

Recommendation for Improvement.

1. Health Infrastructure and Human Resources

- Advocate for endorsement of the O&M survey by the federal government to regularize health worker positions and reduce audit irregularities and ensure sustainable financing for BHS.
- Advocate for flexibility in provincial recruitment rules to allow local governments to hire essential health workers on a contract basis until permanent positions are sanctioned.
- Prioritize infrastructure upgrades using federal complementary grants, especially for equipping health posts and birthing centers with minimum required furniture, diagnostics, and delivery facilities.
- Lobby for alignment of federal mandates with HR and financial provisions, ensuring policy decisions are supported with operational resources.
- Conduct need assessment for supply of furniture and equipment.

2. Policy Environment

- Develop and implement comprehensive local health laws, policies, and guidelines aligned with federal health policy, ensuring practical translation at the ward and facility level.
- Enhance legal and technical capacity within municipalities through regular training and the hiring of legal and public health experts.

3. Basic Health Service Delivery

- Implement a targeted immunization improvement plan, including mobile clinics, defaulter tracking, and enhanced outreach in low-coverage wards.
- Strengthen maternal and child health services by expanding 8 ANC visits, postpartum care, and KMC practices, supported by refresher training for ANMs.
- Integrate NCD and mental health screening into BHS delivery package using WHO PEN and mhGAP tools, with task-sharing to paramedics.

4. Finance Allocation and Budgeting

- Develop clear operational guidelines for budgeting and expenditure, especially for community-based incentives, medicine procurement, and program activities.
- Develop and follow an annual rolling procurement plan for medicines and logistics to minimize stock-outs and ensure timely service delivery.
- Advocate for a revision of equalization grant indicators to consider population vulnerability and service accessibility in remote areas.
- Prepare internal health expenditure guidelines to standardize spending, improve audit compliance, and address HR financing legitimacy issues.
- Engage with provincial and federal levels to secure sustainable contributions for essential drugs and service delivery beyond conditional grants.

5. Governance and Planning

- Strengthen participatory planning and leadership capacity by institutionalizing ward-level involvement in annual budgeting and providing targeted orientation and coaching to elected officials and HFOMC members on health systems, strategic planning, and prioritization of overlooked areas such as NCDs, adolescent, and mental health.
- Improve monitoring, evaluation, and financial governance through timely trimester reporting, full SUTRA compliance, and implementation of internal control frameworks to enhance transparency, correct implementation gaps, and reduce fiscal irregularities.

1. Coordination and Federalism.

- Operationalize a Multisectoral Health Coordination Committee with clear Terms of Reference and regular meeting schedules to foster collaboration between health, WASH, education, agriculture, and disaster management

Section 4: Summary

Common Issues and Challenges

1. Health Infrastructure and Human Resources
   - Health facilities across all three municipalities suffer from inadequate infrastructure, with many operating in temporary buildings and lacking essential diagnostic equipment, sanitation, and advanced services such as BEONC, CEONC, and NCD care.
   - There are severe human resource shortages, with a limited number of sanctioned government positions, over-reliance on contract staff, and legal restrictions on new HR recruitment—hindering consistent service delivery.
   - Institutional and legal hurdles, such as unresolved hospital location disputes and unclear financing of contractual staff, have further complicated service expansion and fiscal accountability.
   - The national mandate of one facility per ward is not matched by resource allocation or staffing, putting strain on already stretched municipal capacities.

2. Health Policy and Legal Framework
   - Except for Nepalgunj sub metropolitan, none have developed local health-specific laws, strategies, or policies, resulting in over-dependence on federal/provincial frameworks.
   - Limited legal expertise and technical support at the local level hinder the formulation of contextualized health legislation and planning tools.

3. Basic Health Service Delivery
   - Key primary health care services—including maternal and child health, immunization, family planning, NCDs, mental health, and geriatric care—remain underdeveloped or poorly integrated into routine services.
   - PHC/ORC outreach services are mostly non-functional, contributing to missed service opportunities, especially in remote and underserved areas.
   - Stock-outs of medicines, vaccines, and FP commodities—often due to unreliable provincial supply chains—disrupt continuity of care.
   - Poor community engagement, weak mobilization of FCHVs and mothers' groups, and underutilization of HFOMCs further impact service effectiveness.
   - Procurement restrictions from federal and provincial levels prevent municipalities from purchasing essential medicines and supplies like Amlodipine and Metformin.

4. Health Financing and Budgeting
   - Health budget utilization is inefficient, with most spending occurring at the fiscal year-end, often without strategic prioritization or adequate internal control mechanisms.
   - A disproportionate share of the health budget is spent on salaries, leaving little room for programmatic activities or community outreach.
   - Federal and provincial contributions are insufficient to cover essential medicine needs, forcing municipalities to reallocate internal resources.
   - Equalization grant criteria based on indicators like institutional delivery and immunization are misaligned with rural and high out-migration realities, disadvantaging these areas.
   - High proportion of audit-flagged financial irregularities reflect weak fiscal governance and absence of financial control guidelines.

5. Governance, Strategic Planning, and M&E

- Participatory planning processes are weak or tokenistic; settlement-level inputs are often ignored, and strategic priorities (e.g., adolescent health, NCDs, mental health) are sidelined due to poor practice of evidence-based planning.
- Lack of strategic vision and fragmented investment in short-term projects undermine sustainable health system strengthening.
- Monitoring and evaluation systems are underperforming, with delayed reporting, poor SUTRA compliance, and weak implementation feedback loops.
- Technical capacity of elected officials and HFOMCs to engage in health planning and governance remains limited.

6. Coordination, Integration, and Federalism

- Non-functional Multisectoral Coordination Committees have resulted in fragmented planning and siloed implementation across health, WASH, education, and environment sectors.
- There is little integration of health services with urban development challenges such as pollution, road accidents, industrial risks, and environmental health threats—especially in urban areas like Nepalgunj.
- Intergovernmental fiscal transfers remain crucial for even the basic operation of health services, highlighting local dependency on higher-tier support.
- Opportunities for efficient health service delivery—such as rationalizing health facility locations and resource pooling—have not been fully explored.

Recommendations:

1. Health Infrastructure and Human Resources

- Improve health infrastructure by co-financing with provincial governments, prioritizing upgrades in high-volume facilities, and ensuring basic standards (WASH, electricity, diagnostics).
- Address HR shortages through advocacy for sanctioned positions in BHSCs/UHCs, implementation of O&M-based organograms, and revision of provincial restrictions on contractual hiring.
- Develop local HR strategies including partnerships with medical colleges for internships, and deployment of specialist services in coordination with provincial and federal authorities.
- Strengthen emergency referral systems and scale up diagnostic services at the municipal level using cost-effective technology and targeted investments.
- Advocate for revision in the HR policy to allow municipalities limited flexibility in hiring essential staff on a contractual basis with clear financing mechanisms.
- Resolve location and service duplication issues through evidence-based facility rationalization and mapping.

2. Health Policy Environment

- Support municipalities to formulate local health acts or bylaws and strategic plans, contextualized to local needs, building on the federal and provincial policy framework.
- Tailor legal instruments and procedures to local contexts and establish technical/legal advisory support through MuAN or GiZ.
- Develop internal control guidelines and long-term strategic plans to address scattered programming and fiscal irregularities flagged by audit bodies.

3. Basic Health Service Delivery

- Reactivate community outreach services with mobilization of health workers, logistics, and incentives for FCHVs and Mothers' Groups to increase coverage in underserved areas.
- Ensure continuity of medicine and vaccine supplies through municipal-level stock monitoring, buffer stock management, and advocacy to lift procurement restrictions.
- Integrate under-addressed services like NCDs, mental health, geriatric, and disability-inclusive care into routine service delivery.

- Expand community awareness campaigns targeting ANC, institutional deliveries, maternal nutrition, and early service uptake.
- Strengthen referral and emergency obstetric care, particularly in urban hubs like Nepalgunj, to reduce maternal morbidity and mortality.
- Revitalize HFOMCs and Mothers' Groups by clarifying roles, offering refresher training, and linking them to ward-level planning and grievance redress systems.
- Advocate to ensure operational autonomy for municipalities to procure essential medicines and medical supplies by revising procurement-related bottlenecks at federal and provincial levels.

4. Health Financing and Budgeting
    - Adopt multi-year (Mid Term Expenditure Framework), needs-based health budgeting to reduce fiscal year-end expenditure bottlenecks and improve fund utilization.
    - Create transparent procurement and expenditure tracking systems, including digital dashboards and internal audit mechanisms.
    - Advocate for revisions to the equalization grant formula, ensuring it accounts for rurality, out-migration, and remoteness to improve equity.

5. Governance, Strategic Planning, and M&E
    - Institutionalize participatory ward-level health planning to ensure real community health needs inform municipal budgets and programs.
    - Develop a 3–5 year municipal health strategy aligned with UHC and SDG goals, with yearly targets and program indicators.
    - Digitize health services and reporting systems (including private sector integration) to enhance real-time monitoring and evidence-based decision-making.
    - Strengthen M&E capacity through dedicated staff, partnerships with academic institutions, and compliance with federal reporting standards like SUTRA.
    - Regularly orient elected representatives and HFOMCs on health systems, planning processes, and strategic prioritization.

6. Coordination, Integration, and Federalism
    - Institutionalize Multisectoral Health Coordination Committees (MHCCs) in all municipalities with clear ToRs, legal backing, and regular meetings.
    - Integrate health into broader municipal planning including education, WASH, agriculture, and environment to address social determinants.
    - Promote joint planning and resource pooling across wards and municipalities to improve efficiency and avoid duplication.
    - Mainstream health in local urban development and environmental planning—addressing issues such as pollution, occupational hazards, and road safety within the municipal health strategy.

Conclusion

This Health Need Assessment underscores the multifaceted challenges and opportunities facing Nepalgunj Sub-Metropolitan, Panchadewal Binayak, and Triveni Municipalities in delivering equitable, quality, and inclusive basic health services. Despite constitutional guarantees and policy commitments, systemic gaps persist across infrastructure, human resources, service delivery, planning, financing, governance, and multisectoral coordination. The findings reveal that while municipalities have made commendable strides in BHS delivery and improving health governance—such as expanding health facilities, conducting MSS assessments, and initiating localized programs—critical bottlenecks remain, particularly in strategic planning, HR regularization, and integration of under-addressed services like NCDs and mental health. Strengthening municipal health governance requires a coordinated push for policy reform, fiscal decentralization, and capacity-building, alongside the operationalization of Multisectoral Health Coordination Committees. By aligning local initiatives with national frameworks and leveraging intergovernmental

support, municipalities can transform health systems to be more resilient, inclusive, and responsive to the needs of marginalized populations. This assessment serves as both a diagnostic and a roadmap for targeted interventions, collaborative action, and sustained investment in municipal health systems.