Final Draft Report

Environment and Social Systems Assessment (ESSA) of Nepal Quality Health System Program for Results

January 2023

CONTENTS

APPENDICES

ABBREVIATIONS

BES	Brief Environmental Study
CP	Core Principles
DHIS2	District Health Information Software
DHO	District Health Office
DLI	Disbursement Linked Indicators
DoHS	Department of Health Services
DPs	Development Partners
DPHO	District Public Health Office
EHCS	Essential Health Care Services
E&S	Environmental & Social
EIA	Environmental Impact Assessment
EHR	Electronic Health Record
EMDTs	Emergency Medical Deployment Teams
EMR	Electronic Medical Record
GESI	Gender Equality and Social Inclusion
HCW	Health Care Waste
HCWM	Health Care Waste Management
HMIS	Health Management Information System
E&S	Environmental and Social
ESMF	Environmental and Social Management Framework
ESMP	Environment and Social Management Plans
ESSA	Environmental and Social Systems Assessment
FCDO	Foreign, Commonwealth and Development Office
FY	Fiscal Year
GBV	Gender-based violence
GESI	Gender Equality and Social Inclusion
GIZ	German Agency for International Cooperation
GoN	Government of Nepal
GRID	Green, Resilient, and Inclusive Development
GRM	Grievances Redress Mechanism
HIB	Health Insurance Board
IAs	Implementing Agencies
IDA	International Development Association
IEE	Initial Environmental Examination
IP	Indigenous People
IPDP	Indigenous People Development Plan
JFA	Joint Financing Arrangement
LGOA	Local Government Operational Act
LGs	Local Governments
MoHP	Ministry of Health and Population
MSS	Minimum Service Standards
OCMCs	One-stop Crisis Management Centres
NHFS	Nepal Health Facility Survey
NHS-SP	Nepal Health Sector Strategic Plan
NQHSP	Nepal Quality Health System Program
OHS	Occupational Health and Safety
OOP	Out of Pocket
PAP	Program Action Plan

PDO	Program Development Objectives
PforR	Program for Results
PHCC	Primary Health Care Center
PHD	Provincial Health Directorate
PIU	Project Implementation Unit
PPE	Personal Protective Equipment
RBL	Results-Based Lending
RHD	Regional Health Directorate
RRTs	Rapid Response Teams
SDGs	Sustainable Development Goals
SEA	Strategic Environmental Analysis/Sexual Exploitation and Abuse
SH	Sexual Harassment
SIA	Structural Integrity Assessment
SNGs	Sub National Governments
SR	Sub Results
UNDP	United Nation Development Program
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCDF	Vulnerable Community Development Framework
VCDP	Vulnerable Community Development Plan
WASH	Water Sanitation and Health
WB	World Bank
WHO	World Health Organization,

SUMMARY

Introduction and Background

1. The Program-for-Results (PforR) lending instrument to be applied for the implementation of the proposed Nepal Quality Health System Program (NQHSP) requires a thorough assessment of the country's environmental and social (E&S) capacity to support the proposed investment. Accordingly, an Environmental and Social Assessment (ESSA)was carried out with the overall objective of comprehensively reviewing and analyzing the existing environmental and social systems, and procedures of various implementing agencies (IAs) and stakeholders of the health sector. The specific objectives of the ESSA were to:

i) review legal and policy frameworks/provisions for environment and social (E&S) risk management in the health sector;
ii) identification of E&S issues and gaps, and challenges in E&S compliance and management under PforR program boundary;
iii) assessment of institutional systems and capacities of implementing agencies to implement the Program;
iv) recommendation and development of a Program Action Plan (PAP) to address the E&S gaps and improve the current risk management system; and
v) carry out multi stakeholder consultations and disclosure

2. The ESSA primarily relied on desk review of existing information and data sources, complemented by primary data collection/assessment through consultations, interviews, and interactions with key stakeholders. Field visits were made Gandaki Province and Province Number 1 for interactions with provincial and local stakeholders including healthcare workers. The study also consulted with key stakeholders on the findings of the draft ESSA report, including proposed measures to strengthen program risk management capacity that have been identified through the assessment.

Nepal Quality Health Systems Program and PforR Scope

3. The World Bank (WB) is proposing to support the first phase of the Government of Nepal's (GoN's) National Health Sector – Strategic Plan (NHS - SP; 2022–2030) through a Progam_for_Results (PforR) financing instrument.The PforR is part of the sector wide approach (SWAp) whereby the GoN, WB and other development partners jointly fund the entire health sector program.The scope of the Nepal Quality Health System Program (NQHSP) will be to support all federally funded and executed activities to be implemented directly by federal spending units and federally funded health conditional grants to provincial and local governments in two of the seven provinces of Nepal (Province 1 and Gandaki).

4. The Program Development Objectives (PDO) of the NQHSP is to improve quality of healthcare, enhance financial protection in health and strengthen health emergency preparedness in Nepal. The PDO indicators are as follows:

(i) Increase in the number of health facilities meeting minimum standards of quality of care at the point of delivery;
(ii) Reduction in out-of-pocket expenditure on healthcare; and
(iii) Increase in timely response to health emergency events by rapid response teams (RRTs) and emergency medical deployment teams (EMDTs) as per the national guidelines.

5. At the activities level, the Program will primarily focus on:

- expediting the reforms to improve health facility readiness for quality healthcare at all public sector health facilities as per the government's Minimum Service Standards
- building on the momentum of health data systems strengthening, mainly with regards to digitalizing health data to increase data quality and use, enhance efficiency of health systems, and improve quality of healthcare
- supporting introduction and scale-up an end-to-end digital system, processes, and capacities to manage essential medical equipment
- increased and sustained coverage of health insurance particularly among poor and vulnerable population, while pursuing institutional and digital reforms to strengthen the insurance system.
- supporting sub-national governments with measures to build their institutional capacity and leadership in prioritizing and developing their health sector plans using data and evidence.
- strengthening health emergency preparedness at provincial and local levels
- supporting systematic formation, capacity building, equipping and deployment of rapid response teams (RRTs) and emergency medical deployment teams (EMDTs) as per the new RRT and EMDT guidelines at provincial and local levels.

Borrowers Systems Relative to Core Principles

6. Based on the assessment and stakeholder consultations, the ESSA determined that the following three of the six Core Principles apply to the Program:

Core Principle # 1: Promote environmental and social sustainability in the Program design; avoid, minimize, or mitigate adverse impacts, and promote informed decision making relating to the Program's environmental and social impacts.

7. The capacity to manage E&S risks exits but needs to be strengthened in terms of human resources and budget. The sector has developed set of guidelines and good practices but at present, there is no sector wide framework for screening and identifying any potential environmental and social issues before undertaking any works. There is no dedicated capacity to look into E&S risks particularly with regard to HCWM.
The Program design promotes environmental and social sustainability in several ways. This is evident in terms of the following results that the Program is expected to generate. For instance, improvement in digital database for MSS related to healthcare waste management (HCWM) & occupational health safety (OHS) will contribute towards better design and planning of HCWM and OHS in healthcare facilities (HCFs). The proposed Program will contribute to the GRID agenda in Nepal in the procurement and upkeep of medical equipment. Improvement in bio-medical technical capacity to support hospitals with repair and maintenance will reduce medical equipment waste. Systematic formation, capacity building, equipping and deployment of rapid response teams (RRTs) and emergency medical deployment teams (EMDTs), as per the new RRT and EMDT guidelines at provincial and local levels, will result in effective and sustainable structures and mechanisms for preparedness and response from the bottom of the pyramid.

8. Likewise, the Program will contribute towards promoting sustainable social benefits in several ways. For instance, the improvement in readiness and service provision at the public hospitals and primary level facilities, as per MSS, will benefit poor and marginalized communities as they don't have other options for accessing health services. Poor and vulnerable groups' access to quality health will significantly improve due to increased coverage of the Program's support to increased and sustained coverage of health insurance program particularly among poor and vulnerable populations. There will be more coherent, objective and evidence-based allocations for public health activities and basic healthcare delivery customized to local circumstances and needs. Gaps identified through MSS assessments will be addressed to improve quality of healthcare as well as to mobilize

resources for deploying RRTs and EMDTs in case of health emergency events. This will not only increase the efficiency of the local health system but is also expected to enhance equity through more nuanced targeting of poor and vulnerable and out of reach communities. Furthermore, relevant equity indicators will be incorporated in the health management information system (HMIS) to support local governments (LGs) improving equity. The Program's sub-results area on health data systems, strengthened local level planning and emergency health preparedness will include gender and inclusion considerations, for example: disaggregation of data; addressing the needs of women, poor and vulnerable.

Core Principle # 3: Protect public and worker safety against the potential risks associated with: (i) construction and/or operations of facilities or other operational practices under the Program; (ii) exposure to toxic chemicals, hazardous wastes, and other dangerous materials under the Program; and (iii) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards.

9. Provisions for labor worker safety have been made in national regulatory and policy framework; but it is not adequate (no separate legislation on OHS) on addressing the issues related to the OHS. Although the Program will not support any major civil works, there are issues related to infection control and good operating practices by healthcare workers and other workers dealing with chemicals, medical equipment, and risks from infectious diseases. The provisions in Core Principle 3 are considered as part of the occupational health and safety issues related to chemicals usage, medical equipment and handling infectious waste and medical waste. However, challenges in implementation and monitoring compliance of E&S safeguard measures persist due to shortcomings in institutional capacities and adequacy of dedicated human resources and budget, particularly at the sub-national level.

10. The Environmental and Social Management Frameworks (ESMF), applied by the MoHP in earlier projects, need to be updated, contextualized, and uniformly applied across all sectoral projects/programs to address the E&S risk of the entire health sector. This updated ESMF needs to incorporate relevant provisions in GoN’s legislation, standards, and programs for more effective management of E&S concerns such as HCWM, OHS, and targeted approaches/frameworks for enhancing the access of poor and vulnerable groups to health services and clear institutional roles and responsibilities.

Core Principle # 5: Give due consideration to the cultural appropriateness of, and equitable access to Program benefits, giving special attention to the rights and interests of the Indigenous Peoples and to the needs or concerns of vulnerable groups.

11. In recent times, political commitment towards gender equality and social inclusion (GESI) has led to integration of GESI into the GoN systems. This is evident in terms of high priority accorded to GESI integration in GoN's policy and regulatory regimes. Special legal/regulatory provisions are in place for safeguarding the interest/concerns of IPs and vulnerable people, which is amply reflected in the ESMFs applied by the MoHP in earlier projects particularly in the recent COVID-19 Emergency Response and Health Systems Preparedness Project. An Indigenous People Management Framework (IPMF) has been inbuilt in this framework to i) ensure inclusion of targeted communities in the consultation process of the Program; ii) avoid, minimize, and mitigate any potential adverse impacts on indigenous and vulnerable communities; and iii) ensure vulnerable peoples’ participation in the process of planning, implementation, and monitoring of the sub-program facilities. There is a need to give continuity to the application of this framework during the implementation of this Project.

12. Furthermore, MoHP GESI Strategy, 2021 is focused on mainstreaming GESI in the Health Sector policies, strategies, system, plans, programs, budget and monitoring and evaluation of the federal, provincial, and local governments. It envisages promoting equitable access of health services by increasing targeted communities' access to and utilization of basic health services. The need now is to ensure the effective roll out and implementation of the Strategy at all levels of the federal structure for delivery of GESI responsive health services.

Key gaps/challenges requiring immediate actions

13. The ESSA has identified key gaps/challenges requiring immediate actions which have been segregated in terms of i) Institutional arrangement; ii) Capacity to manage and implement E&S safeguard measures; and iv) Monitoring compliance of implementing agencies across the three levels of the federal structure.

A. Institutional arrangement

- The provincial and local governments lack adequate policies/safeguards and systems for the implementation of environmental or social risks management applicable to the program.
- Lack of an E&S framework for the health sector that can be uniformly applied across all sectoral project/programs.
- Lack of effective mechanism for coordination between federal, provincial, and local government line agencies for managing the implementation E&S measures.
- Lack of GESI responsive structure and adequate resources for implementation in IAs at the provincial and federal level.

B. Capacity to manage and implement E & S risk management m**easures**

- The capacity, at the provincial and local governments and in healthcare facilities, for managing environmental and social risks are inadequate and need strengthening in terms of knowledge/skill and financial resources.
- Managing wastes generated from healthcare facilities, including e-waste, has emerged as one of the serious health issues in Nepal. There is also the issue of capacity and resources gaps in managing OHS risk related to HCW handling.
- Maintenance and operation of equipment related to disinfection and treatment of healthcare waste is also challenging due to shortage of skilled technical resource and lack of budget.
- Inadequate and/or ineffective identification and outreach of ultra poor families has resulted in their low coverage by the health insurance program and challenges in rapid response or emergency response.

C. Monitoring Compliance

- Environment and social performance/compliance monitoring and verification audit procedures for meeting minimum conditions related to environmental and social safeguards at all levels of governments are inadequate.
- The federal and sub-national governments lack adequate budget for environment & social management including for monitoring safeguards measures.
- The lack of integrated HMIS and EMR results in proper monitoring mechanism and GESI strategy.

Action Plan to Enhance Environment and Social Management Capacity/Performance

14. The proposed action and implementation plan to enhance E&S management performance and capacity are presented in the table below.

Action and implementation plan to enhance E&S management performance and capacity					
Action Description	**Source**	**DLI#**	**Responsibility**	**Timing**	**Completion Measurement**
Three district level hospitals, each in province 1 and Gandaki province equipped with i) functional technology (autoclave, needle cutter and other present and in working condition etc.) ii) trained and dedicated human resource to operate autoclave and other equipment iii) adequate budget for complete end disposal of health care waste management as per the National health care waste management, standards and operating procedures 2020 .	**DoHS/Provincial Health Directorate**	**No**	**Provincial Hospitals/Rural & Urban**	**2025**	**Guidelines for end disposal of healthcare waste present and activities carried out accordingly in selected hospitals**
MOHP's GESI Strategy to be rolled out at the Local Levels ensuring that i. GESI data is incorporated into the HMIS with GESI reporting, and iii. Mechanism for coordination with local authorities and committees to streamline GESI in access and healthcare service delivery.	**MOHP/ Local Levels**	**No**	**Local Levels/ health facilities**	**2024 and continuous**	**Key functions of Local Levels under GESI strategy with HMIS integration and GESI mechanism carried out in Program areas**
Prepare and endorse Sector wide ESF (or guideline) for all the activities 9including civil works) executed by MoHP	**MOHP**	**No**		**2025**	**An endorsed ESF**
Outreach and enrollment of ultra poor households based on the defined GESI categories in the health insurance scheme	**Health Insurance Board (HIB)**	**DLI 2**	**HIB/ Local Levels**	**2025 and continuous**	**Achievement of DLI targets as defined under DLI matrix**
Health Emergency Preparedness and Response plans to include local authorities, committees, and community participation and healthcare	**DOHS/EDCD**	**DLI 5**	**EDCD/Local levels**	**2025 and continuous**	**Achievement of DLI targets as described under DLI matrix**

waste management					
Use of eGP system throughout the procurement cycle	**DOHS**	**No**	**DOHS**	**Continuous**	**At least 10% of annual procurement of DOHS to be tested to be channeled through e-GP system in entirety, by 2nd year. To be scaled up depending on the lessons.**
Implement internal control guidelines	**MOHP**	**No**	**MOHP and cost centers**	**Continuous**	**Provision of guidelines, trainings, conduct of audit action committees and resolution of audit queries**
Enhance the existing GRM mechanism to make it more integrated, systemic and digitized	MoHP/DoHS, Provincial Government, LGs & Healthcare Facilities	**No**	**MOHP and DOHS**	**Continuous**	GRM mechanism digitized & functional

1 INTRODUCTION

1.01 Nepal's Health Sector

15. The right to free basic health services and emergency health services from the State is enshrined as a fundamental right of every citizen in the Constitution of Nepal 2015. Accordingly, it is the responsibility of the State to ensure that every citizen has easy availability of and equal access to quality healthcare. Nepal's legal and policy framework for the health sector is geared towards fulfilling the constitutional provisions to ensure easy availability of and equal access to quality healthcare for all without financial hardship – and achieve Universal Health Coverage (UHC) – in line with the country's commitment to achieve Sustainable Development Goals by 2030.

16. Periodic health sector policies, strategies and implementation plans of the Government of Nepal (GoN) have been instrumental in significantly improving the health status of the Nepalese people over the past several decades. Life expectancy has steadily increased to 70 years in 2017, up from about 38 years in 1960; infant mortality rate also steadily declined from 216 to 27 per 1,000 live births between 1960 and 2018; and maternal mortality ratio decreased from 553 to 186 per 100,000 live births between 2000 and 2017, and fertility rate decreased from 5.2 per woman in 1990 to 1.8 in 2020 (World Bank 2020). In the F/Y 2021/22, Nepal had a total of 6,266 health facilities, comprising 201 public hospitals, 189 primary healthcare centers, 3,794 health posts and 2,082 nonpublic facilities, delivering basic health care services. Primary health care services were also provided by 11,699 Primary Health Care Outreach Clinic (PHCORC) sites.[1]

17. Yet, despite significant progress, challenges remain in access, equity, quality and affordability of healthcare making it increasingly difficult to sustain the gains in health outcomes. Though considerable expansion of healthcare delivery structures and increased availability of services have been achieved in the past few decades, the quality of healthcare is poor due to weaknesses in the health system. The COVID-19 pandemic exposed weaknesses in Nepal's health system, particularly in its readiness to mitigate the impact of the unprecedented health crisis. Despite an enabling policy environment, system's constraints, weak capacity and inefficiencies have led to poor absorption of health sector budget (e.g. reduced from 82 percent in FY 2018 to 67 percent in FY 2021). The capacity issues, for health planning and programming as well as fiduciary management, are more pronounced at the sub-national levels.

18. As a reform under its sector strategy, the Ministry of Health and Population (MoHP) introduced the Minimum Service Standards (MSS)[2] as a framework for continuous improvement of quality at the point of delivery. MSS implementation was initiated in 2018 in secondary hospitals and has been expanded covering nearly all existing hospitals at different levels; however, the pace of roll out at primary level facilities is quite slow, and with rapidly increasing number of primary hospitals, the coverage gap is likely to increase. Assessment of the gaps in readiness has yet to yield the intended results due to little focus on addressing the identified gaps in a timely manner.[3] Though a digital database has been used by some provincial hospitals, it is standalone and not linked to existing Health Information Management System (HMIS) to systematically monitor the progress particularly for primary level facilities.

[1] Annual Report 2077/78 (2021/22), Department of Health Services, Government of Nepal, Ministry of Health and Population
[2] MSS primarily focuses on improving the readiness of a health facility to deliver quality health services and consists of multiple criteria clustered under three broad categories: governance and management (20% weightage); clinical services (60% weightage) and support services (20% weightage).
[3] An MSS status assessment of 89 hospitals in FY 2020/21 showed an improvement between 2 percentage point to 13 percentage point among different levels of hospitals over a year, however overall average score was still low, ranging from 44 percent for tertiary level hospitals to 59 percent for secondary A level hospitals.

19. Nepal aims to digitize health information systems down to the lowest level of healthcare facilities in order to enhance health system efficiency and improve the quality of data and healthcare services. Nepal started digitization of HMIS in 2014 and introduced the District Health Information Software (DHIS2)[4] platform in 2017. In fiscal year 2021/22, all 753 municipalities and 2,164 health facilities (around one-third of all health facilities) report monthly online on DHIS2 (MoHP/DoHS Annual Report 2021/22). The use of data for policy and programming is low particularly at the local level as their focus has been on data entry of large volumes of paper-based data submitted by many health facilities without an online data entry facility yet. The 2017 e-Health Strategy and its Implementation Roadmap emphasize MoHP's ambitions to digitize health data systematically and comprehensively by introducing and expanding Electronic Medical Record and Electronic Health Record (EMR/EHR) for hospitals and electronic health database for recording and reporting at the lower-level facilities.

20. Medical equipment is a crucial component of healthcare delivery, and COVID-19 pandemic has shown the growing importance of medical equipment at all levels.[5]A third-party verification (supported by a USAID project)of medical equipment and inventory management of two central level hospitals in 2021 revealed the stark situation of poorly managed equipment. During COVID-19 response, there was a large influx of medical equipment, mostly donated, with many ending up in hospitals and smaller facilities with little or no capacity to operate and maintain them. Thus, many of these might pass their lifetime without being used. Though several fragmented initiatives addressing different areas of a medical equipment management cycle – including specification standards, inventory management system, and repair and maintenance hubs – have been undertaken with support from development partners (DPs), absence of a comprehensive system has resulted in inefficiencies and waste of scarce resources, ultimately impacting on healthcare quality.

7. In 2015, the GoN introduced National Health Insurance Program, governed, and implemented by Health Insurance Board (HIB), to improve financial protection and service delivery. Although rolled out to all 77 districts, the share of population covered remains low at 18 percent (2022)[6] and the rate of non-renewal is quite high (one in four in 2020). Only 450 hospitals and facilities (around 5% of all health facilities) – public and private – have been empaneled. Despite legislations mandating subsidization for the poor and vulnerable populations[7], absence of adequate outreach, timely identification and verification of ultra-poor households (carried out in only 26 of the 77 districts so far), which is outside the purview of Health Insurance Board(HIB), has led to poor enrollment of the ultra-poor.

1.02 Nepal Quality Health System Program

21. In the past two decades, the World Bank (WB) has provided continuous support to the GoN's health sector programs through the following sector-wide approach (SWAp) programs: i) Nepal Health Sector Program (NHSP; 2004-09); ii) Nepal Health Sector Program II (NHSP II; 2010-2015); and iii) Nepal Health Sector Program III (NHSP III; 2016-2021).In the future, the WB aims to address the

[4] District Health Information Software (DHIS2), used in more than 60 countries around the world, is an open-source software platform for reporting, analysis and dissemination of data for all health programs, developed by the Health Information Systems Program (www.dhis2.org)

[5]As important as the equipment are for quality, efficiency and sustainability of health services, poor management can adversely impact not just the trust on the healthcare system, but also affect health outcomes.

[6] The coverage of the population varies substantially across the provinces: the highest being in Province 1 (35%), second highest in Gandaki (26%) and the lowest being in Madhesh (5%).

[7] The Health Insurance Act of 2017 mandates providing full subsidies in enrollment fees to poor and vulnerable population sub-groups – the "ultra-poor", the elderly, and the individuals with select disease conditions – and partial subsidies (50 percent) to female community health volunteers.

challenges in health sector through the Nepal Quality Health System Program (NQHSP) under the results-based Program-for-Results (PforR) financing instrument tby supporting GON's Nepal Health Sector Strategic Plan (NHS-SP; 2022-2032).The NHS-SP has the following strategic objectives: (i) To make the health system resilient, responsible, and accountable that is aligned to the federal structures; (ii) To address wider determinants of health; (iii) To reduce financial hardship associated with health service utilization; (iv) To ensure equity and access to quality healthcare services; and (v) To manage population; migration and increasing urbanization. The proposed PforR operation will contribute to three of these strategic objectives (I, ii & iv).

22. The NQHSP will provide financial support for the first five years (2023-2027) of the NHS-SP through an International Development Association (IDA) concessional loan of US$100 million and a Trust Fund grant of US$4 million. The GoN will finance the NHS-SP jointly with Development Partners (DPs), including the WB, who are part of the Health SWAp. This will also be complemented with financing by provincial and local governments for health sector activities under their jurisdiction. In addition, the WB has been at the forefront supporting GoN in its health response to the COVID-19 pandemic to save lives through a dedicated operation. Further, the Bank has worked extensively in many other countries and supported their efforts to strengthen health systems and improve quality of healthcare services and has delivered lasting impacts. Lessons learned from its experience in Nepal and globally will provide valuable insights which would help design sustainable and impactful interventions.

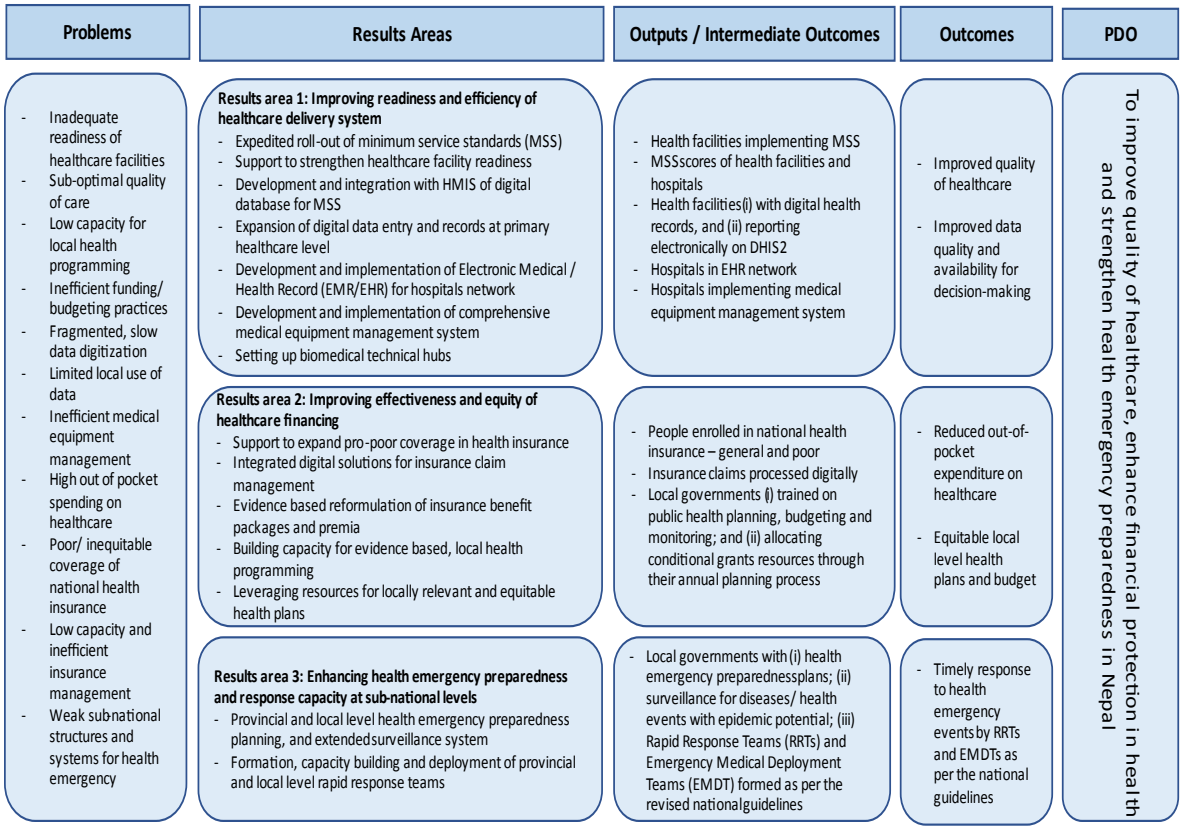
23. The NQHSP will support selected components of health systems, not only to provide impetus to ongoing but slow-moving reforms from the current sector program, but also to introduce critical new reforms for stronger and more resilient healthcare system. The scope of the Program will be to support all federally funded and executed activities to be implemented directly by federal spending units and federally funded health conditional grants to provincial and local governments in two of the seven provinces of Nepal (Province 1 and Gandaki).The selected provinces – Province 1 and Gandaki – are among the better performing provinces (above national average) when it comes to healthcare delivery and health systems performance. The nature of reforms proposed under this Program is relatively upstream but relevant in the context of Nepal graduating to a middle-income country over the program period. To demonstrate results swiftly and effectively, these reforms will require some basic level of functioning health system which these two provinces offer. The reforms, tested and implemented in these two provinces, can be subsequently scaled-up to provinces which have lagged behind but are expected to catch up through extensive support from other DPs. The British Government's Foreign, Commonwealth and Development Office (FCDO), the United States Agency for International Development (USAID) and other DPs intend to concentrate their support in the less performing provinces (such as Madhesh, Karnali, and Sudoor Paschim) in the next sector program.

Objectives and Key Results

24. The Program Development Objectives (PDO) of the NQHSP is to improve quality of healthcare, enhance financial protection in health and strengthen health emergency preparedness in Nepal. The preliminary PDO indicators are as follows:

(iv) Increase in the number of health facilities meeting minimum standards of quality of care at the point of delivery;
(v) Reduction in out-of-pocket expenditure on healthcare; and
(vi) Increase in timely response to health emergency events by rapid response teams (RRTs) and emergency medical deployment teams (EMDTs) as per the national guidelines.

25. The linkages between the problems, activities and expected outputs, outcomes and PDO is depicted below in the graphical presentation of the of the Program's Theory of Change (**Error! Reference source not found.**).



Proposed Sub-result Areas

26. The Program has selected seven sub-result areas for the achievement of its objectives. The sub-result (SR) areas primarily comprise a subset of the NHS-SP interventions, outputs, and outcomes. The summary of the sub-result areas is presented in Table 1

Table 1: Description of Sub-result Areas

Sub-results	Description	Amount (USD)
Results Area 1: Improving readiness and efficiency of healthcare delivery system		**USD 50 million**
Sub-result area 1:Minimum service standards	This sub-result area will focus on expediting the reforms to improve health facility readiness for quality healthcare at all public sector health facilities. This will include developing the capacity of provincial and local level stakeholders and health teams to assess and improve readiness and service provision at their hospitals and primary level facilities as per MSS and ensuring flexible resources to the sub-national governments to implement change and fill identified gaps in the two selected provinces (linked to sub-result area 2). The digital database for MSS will be developed further and integrated with the national health information systems (linked to sub-result area 2).	
Sub-result area 2: Data systems	This sub-result area will build on the momentum of health data systems strengthening, mainly with regards to digitalizing health data to increase data quality and use, enhance efficiency of health systems, and improve quality of healthcare. While accelerating the coverage of digital entry of HMIS data (on DHIS2 platform) to all service delivery points (from around 2,200 to over 7,000 public	

Table 1: Description of Sub-result Areas		
Sub-results	**Description**	**Amount (USD)**
	sector healthcare facilities) in the country, this will go a step further to provide impetus to Nepali health system designing, developing and implementing an EMR and EHR system, initially covering the network of primary and provincial hospitals in the two selected provinces. Customized and user-friendly data outputs and dashboards, coupled with capacity building measures (under sub-result area 5), will enable increased used of their own data in the local level health planning and programming.	
Sub-result Area 3: Medical equipment management:	This sub-result area will help introduce and scale-up an end-to-end digital system, processes, and capacities to manage essential medical equipment not just to maximize their life and usage, but also to enhance the efficiency and effectiveness of healthcare. The system will entail the life-cycle management of essential medical equipment[8]. This will entail designing and developing customized digital solution for medical equipment management interlinked with other procurement and supply chain management systems (linked to sub result area 2), setting up and expanding provincial/ sub-provincial hubs with bio-medical technical capacity to support hospitals with repair and maintenance, and developing structures, mechanisms, guidelines, and tools required for the new system. The Program will support the design and development of the system, its piloting and roll out to all primary and provincial hospitals in the two selected provinces.	
Results Area 2: Improving effectiveness and equity of healthcare financing		**USD 35 million**
Sub-result Area 4: National health insurance:	This sub-result area will focus on both demand and supply side interventions for increased and sustained coverage of health insurance particularly among poor and vulnerable population, while pursuing institutional and digital reforms to strengthen the insurance system. Targeting mechanisms and mobilization strategies to be deployed by local levels to identify and enrol poor and vulnerable households into the insurance program will be defined and implemented in the interim until the identification of ultra-poor households by the GoNis completed in all districts. Use of evidence and scientific basis will be promoted in reformulating health insurance benefit package and its costing. Claim management system will be strengthened through adoption of digital solutions, including the use of Artificial Intelligence, to attract more providers in the scheme. The insurance information management system will be strengthened and, to boost its efficiency, interlinked with EHR where the latter is implemented (linked to sub result area 2).	
Sub-result Area 5: Local capacity for health planning, budgeting, execution & monitoring	Under this sub-result area, local levels in the two selected provinces will be supported with measures to build their institutional capacity and leadership in prioritizing and developing their health sector plans using data and evidence (linked to sub result area 2). Flexible resources will be provided through conditional grants to leverage other discretional resources available to sub-national governments (SNGs) (such as equalization grants, revenue-sharing, and own revenue) more effectively allowing coherent, objective and evidence-based allocations for public health activities and basic healthcare delivery customized to local circumstances and needs. This will also, among others, help address gaps identified through MSS assessments to improve quality of healthcare (linked to sub result area 1) as well as to mobilize resources for deploying RRTs and EMDTs in case of health emergency events (linked to sub result areas 6 and 7). This will not only increase the efficiency	

[8]From setting standards and specifications of equipment by level of healthcare facility, needs projection and quantification, procurement and distribution, installation, inventory, and repair and maintenance to decommissioning and disposal of non-repairable or beyond-life equipment.

Table 1: Description of Sub-result Areas		
Sub-results	**Description**	**Amount (USD)**
	of the local health system but is also expected to enhance equity through more nuanced targeting of poor and vulnerable and out of reach populations.	
Result Area 3: Enhancing health emergency preparedness and response capacity at sub-national levels		**USD 14 million**
Sub-result Area6: Preparedness, planning and surveillance	This sub-result area will help strengthen health emergency preparedness at provincial and local levels in the two selected provinces. The SNGs will be enabled to develop, implement, monitor, and periodically review their preparedness plans, encouraging them to allocate resources (linked to sub result area 5) and undertake prompt and contextualized response in the event of an outbreak/ health emergency in their jurisdiction. Additionally, as a critical preparedness measure, events-based surveillance, which is largely limited to sentinel sites (hospitals and health offices), will be expanded to local and community levels for early detection of health events and outbreaks of epidemic potential.	
Sub-result Area7: Rapid response capacity	This sub-result area will support systematic formation, capacity building, equipping and deployment of RRTs and EMDTs as per the new RRT and EMDT guidelines at provincial and local levels in the two selected provinces. This will be backed by the pre-positioning of essential equipment, medical commodities, and supplies for emergency mobilization in case of an event as well as regular simulation exercises to sustain the capacity built. The activities under the third Results Area will result in effective and sustainable structures and mechanisms for preparedness and response from the bottom of the pyramid.	

Implementation Arrangements for the Program

27. The existing government system will be used for program implementation including oversight, financial management, procurement, safeguards, monitoring and evaluation, and reporting arrangements. As the executive agency, the MoHP will have the overall responsibility for providing policy guidance, ensuring an enabling environment, allocating adequate resources, overseeing implementation, and accountability to the WB with regards to the Program. A dedicated team/secretariat, for example a Sector Program Coordination Unit, under the leadership of the Chief of Health Coordination Division will be assigned by MoHP to facilitate sector coordination and support (including for activities related to the Program and the WB) with accountability requirements of DPs under the SWAp modality, guided by a Joint Financing Arrangement (JFA)[9] between MoHP and SWAp partners, including the WB.

28. The Program will be implemented by DoHS, HIB, and the provincial and local governments of the two selected provinces. The activities and budget required to deliver the Program and achieve SRs will be incorporated in the annual work plan and budget of MoHP. This will also include conditional grant resources to the provincial and local governments in the two selected provinces which will follow the same budgeting, fund flow and reporting arrangements as with other health programs funded with conditional grants by the MoHP. The fund transfers are authorized and disbursed through the Treasury system, and upward reporting done through the sub-national financial management information systems. Though not in practice currently, MoHP will establish procedures to ensure physical progress reporting from the sub-national governments implementing the Program as part of its accountability to the WB. For federal level implementing agencies, existing health and financial information management systems, structures and mechanisms will be used for

[9] JFA is an agreed strategic framework for harmonized implementation of the sector program, under Nepal's health SWAp, signed by the Secretaries of Ministry of Finance and MOHP, and heads of respective organizations.

physical and financial reporting. MoHP will submit annual audits[10] for agencies implementing the Program: the federal level agencies as well as the sub-national governments in the two selected provinces. The Bank task team will provide supervision and implementation support through regular engagement with MoHP and bi-annual implementation support and review missions. To the extent feasible, the review missions will be aligned to the joint consultative meetings and annual reviews between MoHP and DPs as part of the Health SWAp.

29. At the province and local level, provincial and local government health offices will execute the program, and report to MoHP. These health offices will develop health related plans/programs, implement, monitor, and evaluate health programs at the provincial/local levels.

30. At the beneficiary health facilities, where most of the Program expenditures will be made, the main frontline actors are the public healthcare facilities (hospitals). Here the Healthcare Facility Management Committees (HCMCs) will be responsible for managing all facility-level activities. Provincial Health Training Centers (PHTC) will provide training support to health related human resources.

1.03 Background and Purpose of the Environment and Social Systems Assessment

31. The Program-for-Results (PforR) lending instrument to be applied for the implementation of the proposed NQHSP emphasizes the use of existing country program systems for safeguards, procurement, and financial management. To comprehend the suitability of PforR investment framework by the WB, it is necessary to conduct a thorough assessment of the environmental and social (E&S) capacity of the country's health sector to support the proposed investment.

Environment and Social Systems Assessment Objectives

32. The overall objective of this Environmental and Social Assessment (ESSA) is to carry out a comprehensive review, analyze and assess the adequacy of the existing environmental and social systems, and procedures of various implementing agencies (IAs) and stakeholders of the health sector including the MoHP, Department of Health Services (DoHS) as well as health related ministry, departments, units and facilities at the sub-national level.The specific objectives are to:

vi) review legal and policy frameworks/provisions for environment and social (E&S) risk management in the health sector;
vii) identification of key E&S issues and gaps, and challenges in E&S compliance and management under PforR program boundary;
viii) assessment of adequacy of institutional systems, mechanisms and capacities of IAs to implement the Program;
ix) recommendation and development of a Program Action Plan (PAP) to address the E&S gaps and improve the current risk management system; and
x) carry out multi stakeholder consultations and disclosure

ESSA methodology

33. The ESSA primarily relied on: i) desk review of existing information and data sources; and ii) primary data collection/assessment through consultations, interviews, and interactions with key

[10] Audits of entities at all three levels of government and state funded organizations are carried outannually by the Office of the Auditor General.

stakeholders. Field visits were made to Gandaki Province and Province no. 1[11] for interactions with provincial and local stakeholders and healthcare facilities to capture opinions, anecdotal evidence, functional knowledge, and concerns. The study adopted the key assessment domains identified in the ToR and supplemented them by more specific questions/issues to be explored.

34. The study also consulted with key stakeholders on the findings of the draft ESSA report, and to discuss/finalize proposed action plans to strengthen program risk management capacity that have been identified through the assessment. Draft ESSA report was disclosed and made available to key stakeholders before the consultation event. All issues raised in formal consultations, as well as comments received following public disclosure, was properly documented in a consultation matrix along with other related information such as date, location, attendance, issues raised and response provided. Based on the comments received, the ESSA report was revised and finalized.

35. The ESSA report is divided into five parts as described hereunder: program description; description of expected program environmental and social safeguards effects (including benefits, adverse impacts, and risks); assessment of borrower's environmental and social management systems relevant to the program (including a description of the applicable borrower systems; assessment of borrower practices and performance record; assessment of the borrower systems against core principles and planning elements); recommendations in the form of proposed action plan to support the program implementation and supporting annexes and reference documents.

1.04 Environmental and Social Effects

The scope of the proposed Bank operation would be to support the NHS-SP, 2022–2032. Thus, NQHSP covers all levels of health sector from primary health care to specialized services under the jurisdiction of the federal, provincial, and local governments .Site-specific environmental issues related to public health facilities vary from low to moderate based on type, location and scope of infrastructures and equipment. The likely environmental issues/risks are presented hereunder.

36. **Disaster-related risks:** Incidence of disaster events has been increasing over the years. Nepal is vulnerable to various kinds of natural disasters such as earthquakes, floods and infectious disease outbreaks like Dengue and COVID-19. Even in these periods of crisis, Nepal must be prepared to manage the fundamental health rights of the affected citizens. This will require preparedness and coordinated efforts.

37. Nepal suffered from two major earthquakes in 2015 (magnitude of 7.8 and 7,3 Richter scale on April 25th. and May 12th. respectively). Approximately 90% of the health facilities in the affected areas were destroyed or severely damaged. The functioning health facilities were overwhelmed and there was a shortage of medical supplies. As a result, the local health system's ability to respond to the health care needs in disaster-affected areas was compromised. Further, climate related risks unevenly impact the health outcomes of the people with vulnerable and marginalized communities at greater risks than others. Despite the incorporation of the Health - National Adaptation Plan (H-NAP), a lack of resource allocation and integration with health budgets to respond to climate-related health risks is a challenge.

38. Inherent weaknesses in Nepal's health systems make Nepal highly vulnerable to health crisis, particularly in its readiness to mitigate the impact of the unprecedented health crisis. Nepal's overall

[11]Proposed Program locations

health emergency preparedness capacities are low when compared globally as well as regionally.[12] The institutions, structures, policies, and plans related to health emergency preparedness and response remain quite limited, and the priority and resources accorded are quite low[13] which is more pronounced at the sub-national levels.

39. **Health care waste management (HCWM):** Medical waste is a particular concern. Nepal's 300 hospitals generate about 15,000 tons of waste every year of which about 50 percent is estimated to be hazardous; 63 percent of healthcare facilities do not dispose of their hazardous waste safely. The MoHP estimates that waste generated per bed is about 1.35 kg/bed per day out of which 37% is hazardous. Disposal of hazardous health care waste often occurs through open incineration or through dumping on dumpsite or riverbanks where its burned or washed into the rivers along with nonhazardous waste. This causes emissions of greenhouse gases as well as toxic pollutants such as dioxin, furan, lead, and mercury**.**

40. According to the preliminary findings of the Nepal Health Post Survey, 2021, MoHP, significant proportion of health care facilities in Nepal do not practice safe disposal of health care waste. This is validated by the fact that 27.4% of HCFs still do not practice safe final disposal of sharp waste while the same for medical waste is 34.8%. When both of these wastes are factored in, 40.3% HCFs in Nepal do not practice safe final disposal of both sharps and medical wastes. This indicates that there is still a lot to be done for improving HCWM. The status of safe disposal of health care waste in HCFs, segregated by province, is presented in the table below.

Table 2: Proportion (%) of Health Care Facilities with Safe Disposal of Health Care Waste

Province	**Safe final disposal of sharps waste***	**Safe final disposal of medical waste****	**Safe final disposal of both sharps & medical wastes**	**No. of health facilities surveyed**
Province 1	71.0	64.8	59.0	254
Madhesh	68.3	55.1	52.5	247
Bagmati	73.0	68.0	59.9	325
Gandaki	81.9	76.7	73.2	198
Lumbini	75.9	67.1	63.2	243
Karnali	70.7	67.3	59.2	129
Sudurpaschim	65.9	57.5	50.9	170
National Average	**72.6**	**65.2**	**59.7**	**1576**

Source: Nepal Health Post Survey, 2021, Preliminary Data Tables, Ministry of Health and Population

41. **Occupational health and safety hazards and risks to health workers:** Health care workers (doctors, nurses, technicians, and other staff are constantly subjected to grave occupational health hazards such as infectious diseases, contaminated puncture wounds, radiation, solvent and chemical exposures and psychological stress among others). Thus, strict adherence to the required indoor environmental safety and the use of proper PPE by health care workers are critical in mitigating their occupational risks. In Nepal, during the COVID-19 pandemic, health workers had to take the risk of

[12]Nepal's all capacities average in the State Parties Self-Assessment Report (e-SPAR) improved from 23% in 2018 and 34% in 2019 to 39% in 2020. This compares low with the regional (63%) and the global average (65%) in 2020.In 2021, Nepal stood at 107th place out of 195 countries (and sixth out of 9 countries in the region) in Global Health Security (GHS) Index with a score of 34 out of 100 (a reduction of 1.6 from 2019).

[13]A World Bank study 'Increasing Investment in Pandemic and Epidemic Preparedness in Nepal 2020' found that total preparedness-related budget of Nepal in fiscal year 2019/20 was US$ 0.73 per capita, which is just about two-fifth of the investment needed (US$1.69) to reach globally 'accepted' level of pandemic preparedness. Of the allocated budget, nearly three-fourth was from the federal level alone.

infecting themselves while providing care for the patients. This led to the infection of thousands of health workers resulting in the death of many healthcare workers in the line of duty.

Environmental Benefits

42. The NQHSP will apply/adapt all relevant provisions of the ESMF developed by the MoHP in August 2020 for the Nepal COVID-19 Emergency Response and Health Systems Preparedness Project[14] and all relevant policies, acts/regulations, standards, and guidelines of the GoN for environment management approaches, procedures, and risk mitigation measures. The benefits that will ensue from the Program are presented hereunder:

43. **Improvement in digital data base related to HCWM in the MSS:** Given that the Program envisages further developing the digital database for MSS and integrating it with the national health information systems, it will also contribute towards improvement of the data base related to HCWM in the MSS. This will provide valuable information to policy/decision makers to take appropriate measures for the improvement of HCWM at the HCF level.

44. **Further strengthening of the government's environment management systems for practical and easy application:** During the Program implementation, it is envisaged that government's E&S management systems at all levels (federal, provincial, and local) will be further strengthened for practical and easy application. Targeted provincial government and municipalities (staff members) will be oriented on the required environment safeguards to be followed while the health care facilities management will be made familiar with the significance of environmental safeguards.

45. **Incorporation of climate considerations on local level planning and emergency health preparedness:** The focus on strengthened local level planning and on emergency health preparedness will incorporate climate considerations. The NQHSP envisages focusing on i) climate-informed local health plans; ii) health preparedness and response capacities for climate-change induced natural disasters and disease outbreaks; and iii) surveillance systems for early detection of climate sensitive diseases.

Social Risks/Issues

46. **Possible exclusion of vulnerable groups and indigenous peoples in emergency response planning and response:** In general, Indigenous People and vulnerable groups, particularly women and people with disabilities, are generally absent during community engagement and risk communication during public health emergency planning process. This results in low access of vulnerable groups to emergency response health services.

47. For instance, in Nepal, women lack adequate access to sexual and reproductive healthcare services during and in the aftermath of disasters. A 2018 survey supported by the Inter-Agency Common Feedback Project in ten flood-affected districts of Nepal found that across 1800 respondents in 10 districts, only one percent felt that their main flood recovery related concerns are being completely addressed. An additional 40 percent mentioned that their concerns are partially addressed. This leaves 61 percent of respondents who feel their concerns are not being addressed. Further, about 50% of female respondents did not have proper access to healthcare. Data from the 2017 floods show that 21,000 pregnant women lacked access to healthcare in the wake of the floods, of whom, 6,700 faced pregnancy-related complications in the following three months.

[14]The ESMF e served as the guiding framework for assessing and managing the environmental and social impacts of the project activities.

Gender wise data shows that women are less likely than their male counterparts to have taken any risk reduction activities, at 81 percent vs. 76 percent. Muslim and Hill Janjati (86 percent each), Hill Dalit (84 percent) and Terai Dalit (82 percent) are the most likely, among ethnic groups, to not have taken any action to mitigate the impact of floods.[15]

48. It is important to ensure meaningful consultation with representatives from vulnerable groups including women, persons with disabilities, and Indigenous People in decision-making in relation to emergency planning and response. This will promote GESI inclusive public health emergency mitigation plan that caters to the needs of women, Indigenous People and other vulnerable groups.

49. **Possible risk of exclusion of indigenous and other vulnerable groups from access to information due to language and cultural barriers, literacy and remoteness:** Many people from marginalized ethnic groups often face difficulties in accessing health information due to application of dialect/language other than their mother tongue which restricts their access to health services.

50. Although in general terms free healthcare is equitable, access to services is not. This is mainly due to inability of many people to reach to health facility because of distance, cost of transport, and, for some, lack of knowledge that services are free of charge, language barrier, and gender barriers. For instance, less than six in every ten births (57 percent) take place at a health facility in Nepal; 43 percent take place at home or on the way to a health facility. This is even more pronounced in mountain areas (where distance to health facilities is major issue) as only 41.7 percent of deliveries were conducted in health institutions in Mountain areas compared to 61 percent in Hill and 56.9 percent in Terai. Waiting times at facilities may also remain as barriers for poor and disadvantaged groups who rely on daily wage labor for their livelihood.

51. One of the major challenges faced by planners and implementers of health programs is addressing geographical barriers limiting the access to health facilities of communities residing in remote and difficult areas. Health facilities in remote locations, in general, have always faced shortage of medical supplies and health care providers. Motivating health care providers to serve in healthcare facilities in remote locations has always been a monumental challenge to health authorities.

52. **Inadequate awareness/application of grievance redress mechanism:** Access to judicial and administrative remedies in the health sector can be severely curtailed due inadequate or ineffective institutionalization of grievances redress mechanism in health care facilities. Lack of awareness, inaccessibility of the grievances redress procedures and low credibility of the redress mechanism can result in social unrest in health care facilities.

53. **Possible exclusion of poor and vulnerable communities from health insurance due to inadequate and/or ineffective identification of families of ultra-poor who are eligible for 100% subsidy:** The Health Insurance Program offers 100% subsidy to ultra poor families; HIV, MDR-TB, Leprosy, severe disability patients and elderly population above 70 years from the premium amount of Nepalese rupees (NPR) 3,500/-. However, poor and inequitable enrollment in health insurance, inefficient health insurance management and weak local health planning has resulted in low coverage of ultra poor families and other vulnerable and marginalized people..

54. **Violence against women and girls:** The GoN has taken significant steps in reforming laws and policies to combat GBV in the country. Yet, violence against women and girls (VAWG) still persist due to deeply entrenched social norms that condone VAWG. As per Clause 3 of the National Action Plan

[15] Inter Agency Common Feedback Project, Flood Perception Survey, May 2018, Round III

against GBV (2010), the MoHP is tasked with the responsibility of providing integrated services to survivors of GBV by establishing hospital based One-stop Crisis Management Centers (OCMCs). These Centers provide free hospital-based health services including identification of survivors, treatment, psychosocial counseling and medico-legal services, and coordination with multi-sectoral agencies that provide survivors access to safe homes, legal protection, personal security and rehabilitation. They also refer clients for specialist health services as required.

55. MoHP data shows that the total annual number of OCMC clients has increased from 187 in 2011/12 (based on seven reporting facilities) to 13,426 in 2021/22 from 88 reporting facilities). Women make up over 90 percent of clients. Though a significant number of OCMC clients in 2021/22 were referred to multi-sectoral service providers outside of the hospital such as police, legal, housing and rehabilitation services, coordination among GBV service providers is likely to be an issue in the absence of a joint action plan among these service providers. According to the self-assessment scorecard completed by 50 OCMCs in March 2020, the indicator related to preparation of a joint action plan with local GBV service providers including the police and local government, was the lowest indicating associated challenges that need to be addressed.[16]

Social Benefits

56. **Strengthened local planning and emergency health preparedness will address the needs of women, poor and vulnerable population by improving their access to health series:** The Program offers potential opportunities for addressing the disparities in access to health benefits. The sub-results area on health data systems, strengthened local level planning and emergency health preparedness will include gender and inclusion considerations, for example: disaggregation of data; addressing the needs of women, poor and vulnerable populations in planning/programming, and their access to services during emergencies.

57. **Improvement in effectiveness and equity of healthcare:** The program is designed to improve the effectiveness and equity of healthcare through two measures.

i) Focus on both the demand and supply side of National Health Insurance for increased and sustained coverage of health insurance particularly among poor and vulnerable population, while pursuing institutional and digital reforms to strengthen the insurance system. Targeting mechanisms and mobilization strategies to be deployed by local levels to identify and enroll poor and vulnerable households into the insurance program will be defined and implemented in the interim until the identification of ultra-poor households by other GoN ministries is completed in all districts.

ii) Strengthening local capacity for health planning, budgeting, execution and monitoring: Local levels in the two selected provinces will be supported with measures to build their institutional capacity and leadership in prioritizing and developing their health sector plans using data and evidence. This will not only increase the efficiency of the local health system but is also expected to enhance equity through more nuanced targeting of poor and vulnerable and out of reach populations.

58. The environmental and social benefit and risks associated with the program activities are presented in the table below.

[16] Review of the scale-up, functionality and utilisation, including barriers to access, of One Stop Crisis Management Centres, DoHS, 2020

Table 3: Environmental & Social Risks & Benefits Associated with Program Activities			
Environmental Benefits	**Environmental Risks**	**Social Benefits**	**Social Risks**
Sub Result (SR) 1:Minimum service standards			
Improvement in HCWM and OHS in HCFs will contribute in Nepal's GRID agenda including in digital database for MSS related to HCWM & OHS	• Lack of Final disposal HCW, including liquid waste, is likely to problematic due lack of integrated approach to HCWM. • Incineration of HCW which is hazardous to the environment.	Improvement in readiness and service provision at their hospitals and primary level facilities as per MSS will benefit poor and marginalized communities & groups.	Vulnerable and ultra-poor from difficult geographical locations will find it difficult to get health services on time due to accessibility, insufficiency, and lack of information & awareness, language, lack of service seeking behaviour, .
SR 2: Data systems			
Inclusion of data related to environmental and social safeguards will provide evidence to decision makers to allocate resources to strengthen environmental and social safeguard systems.	Negligible	Evidence base for targeted local level health planning &programming benefitting women & vulnerable groups.	Inadequate capacity of LGs and PHCCs to collect, assess and incorporate data related to women and vulnerable groupsincludingGESI sensitive data, particularly GBV data, in the HMIS.
SR 3: Medical equipment management			
▪ The proposed Program will contribute to the GRID agenda in Nepal in the procurement and upkeep of medical equipment ▪ Improvement in bio-medical technical capacity to support hospitals with repair and maintenance will reduce medical equipment waste	Inadequate compliance monitoring	Negligible	Negligible

Table 3: Environmental & Social Risks & Benefits Associated with Program Activities			
Environmental Benefits	**Environmental Risks**	**Social Benefits**	**Social Risks**
SR 4: National health insurance			
Not applicable	Not applicable	▪ Improvement in access to quality health service of poor and vulnerable group due to Increased coverage in the national health insurance program. ▪ Improvement in settlement of insurance claims – efficient and timely settlement	Delay in identification/screening of poor and vulnerable communities resulting in their exclusion from national health insurance program Delay in providing the claims, complex procedures (paper works)made by poor and vulnerable will discourage them from getting future services,
SR 5: Local capacity for health planning, budgeting, execution, and monitoring			
Potential for the inclusion of climate induced health concerns in health plans & budgets as well as more effective execution and monitoring of health programs.	Not applicable	▪ More coherent, objective and evidence-based allocations for public health activities and basic healthcare delivery customized to local circumstances and needs. ▪ Gaps identified through MSS assessments will be addressed to improve quality of healthcare as well as to mobilize resources for deploying RRTs and EMDTs in case of health emergency events. This will not only increase the efficiency of the local health system but is also expected to enhance equity through more nuanced targeting of poor and vulnerable and out of reach populations.	Lack of effective implementation of plans/programs
SR 6: Health emergency preparedness, planning and surveillance			
Development, implementation, monitoring and periodically review of preparedness	Lack of effective implementation of plans/programs	Expansion of critical preparedness measure, events-based surveillance to local and community levels for early detection	Lack of effective implementation of plans/programs

Table 3: Environmental & Social Risks & Benefits Associated with Program Activities			
Environmental Benefits	**Environmental Risks**	**Social Benefits**	**Social Risks**
plans & allocation of resources will support prompt and contextualized response in the event of an outbreak/ health emergency and climate induced emergencies		of health events and outbreaks of epidemic potential will benefit poor & vulnerable groups.	
SR 7: Improvement in rapid response capacity			
Systematic formation, capacity building, equipping and deployment of RRTs and EMDTs as per the new RRT and EMDT guidelines at provincial and local levels will result in effective and sustainable structures and mechanisms for preparedness and response (including in climate induced emergencies) from the bottom of the pyramid	Inadequate monitoring & evaluation of safeguard compliance	Access of poor and vulnerable groups to RRTs and EMDT	Lack of effective implementation of plans/programs

2 ASSESSMENT OF ENVIRONMENTAL AND SOCIAL MANAGEMENT SYSTEMS

59. This section broadly covers:
- Overall country system in managing social and environmental impacts specifically related to health sector services; and
- Institutional responsibilities for implementing environmental and social management

National Legal Policy Framework

60. Following the promulgation of The Constitution of Nepal in 2015, health services have now come under the purview of all three tiers of governments (federal, provincial, and local). Schedule 5 of the Constitution lists health policies, health services, health standards, quality, and monitoring, national or specialized service providing hospitals, traditional treatment services and communicable disease control under the power granted to the federal government. Schedule 7 & 8 of the Constitution lists health and sanitation services under the powers granted to the provincial and the local level.

61. Nepal has formulated and/or enacted several policies, instruments and laws that support environmental and social assessment and environmental and social risk management. In alignment of the constitutional right of every citizen to free basic health and emergency services from the State and to live in a clean environment,[17]the GoN has enacted various Acts/Regulations relevant to the health sector. Some of these related to the social aspects of healthcare sector are presented in the tables below (Table 4).

Table 4: Applicable National Legislative Measures, Policy Guidelines and Directives (Social)

S.N.	Policies/Acts	Descriptions of Measures
1	Constitution of Nepal, 2015	The constitution establishes the right relating to health for all the citizens of Nepal. Article 35 of the constitution states that every citizen will have the right to free basic health services and articulates that every citizen will have equal access to health services and every person will have the right to get information about his or her medical treatment. Article 38, which establishes rights to women, says that every woman will have the right to safe motherhood and reproductive health while Article 40 ensures special provision to ensure the health and social security to the Dalit community. Under the policies relating to the basic needs of the citizens, Article 51 h (5) pledges that the state will make the necessary investment in the public health sector to have healthy citizens. Article 51 h (9) says that the state will focus on health research and maintain the required number of health institutions and health workers to ensure wide availability of qualitative health services while Article 51 h (15) vows to ensure health insurance to all citizens. The constitution says that no one will be deprived of emergency health services. Article 271 of the constitution has a provision of declaring a state of emergency in case of a grave emergency such as epidemic in a specific part of the whole country.
2	Public Health	The Act aims to implement the constitutional provision that guarantees

[17] Nepal Law Commission. 2015. *Constitution of Nepal.* Kathmandu, Nepal.Part 2, Section 23.

Table 4: Applicable National Legislative Measures, Policy Guidelines and Directives (Social)		
S.N.	**Policies/Acts**	**Descriptions of Measures**
	Service Act, 2018	the right of the citizens to get free basic health service and emergency health service by establishing access to regular, effective, qualitative, and easily available health services. The Act puts several health services, such as vaccination service, services relating to a communicable disease, mental disease, elderly citizen's health, and emergency health services, among others, under the basic health services. The Act makes it mandatory for all health institutions and health workers to promptly provide emergency health services at the time of need. The Act requires health institutions to adopt necessary measures towards the safety of the employees and preventing infection and disease and says that the health institutions must maintain minimum standards as determined by the Ministry. The Act vows to maintain a rapid response team and emergency physicians to extend health service immediately during emergency circumstances. The federal, provincial, and local levels shall develop emergency health plans and enforce it and while developing the plan, the federal, provincial, and local levels shall adopt standards and directives issued by the federal government, says the Act. The Act also authorizes the local level to declare a state of a public health emergency. The Act also sets up a National Public Health Committee, chaired by the minister of health, to make policy-wise recommendations on the inclusion of the issues of public health into the policy and programs of thematic scope.
3	Health Policy, 2019	The Policy envisages ensuring fundamental health rights of citizens through optimum and effective use of resources, collaboration, and participations. It aims to develop and expand a health system for all citizens in the federal structure based on social justice and good governance and ensure access to and utilization of quality health services. It envisages doing this by: ▪ creating opportunities for all citizens to use their constitutional rights to health; ▪ developing, expanding and improving all types of health systems as per the federal structure; ▪ improving the quality of health services delivered by health institutions of all levels and ensuring easy access to these services; ▪ strengthening social health protection system by integrating the most marginalised sections; ▪ promoting multi-sectoral partnership and collaboration between governmental, non-governmental and private sectors and promoting community involvement; and transforming the health sector from profit-orientation to service-orientation. The policy specifically states that specialized services shall be made easily accessible through health insurance. It aims to do this by: • Strengthening and integrating into the insurance system treatment of services that are not included in basic health services • Linking poor and prioritized target group with sate subsidized health insurance system based on the principles of social justice • Compulsorily bringing the formal sectors into the health insurance system and ultimately covering all citizens by the health insurance

Table 4: Applicable National Legislative Measures, Policy Guidelines and Directives (Social)		
S.N.	**Policies/Acts**	**Descriptions of Measures**
		system • Gradually ensuring the access of poor people to special health services specified by the State.
4	Nepal Health Insurance Act, 2017	This act makes provisions for enrolment of government employees and families of foreign employment into health insurance program. According to the act, the responsibility for enrolling children, elderly and differently-abled persons are entrusted to their respective parents or caretakers. Families are considered as the unit for enrolment into health insurance program.
5	Nepal Health Sector– Strategic Plan, 2022-2032	To sustain the achievements made in the health sector and address the impending challenges, the Strategy envisages to achieve five strategic objectives: i) Enhance efficiency and responsiveness of health system; ii) Address wider determinants of health; iii) Promote sustainable financing and social protection in health; iv) Promote equitable access to quality health services; and v) Manage population and migration. The Strategic Plan calls for: • Mainstreaming GESI concept across the sector including prevention and response of gender-based violence • Developing a mechanism for identification of poor through local government and for subsidized enrolment in insurance schemes Enhancing data disaggregation to better capture disparities in health • Designing and implementing an innovative tailored approach for unreached population • Designating satellite clinics from referral level hospitals targeting underserved and hard-to-reach areas. • Implementing national guideline on disabled-inclusive health services in health care facilities • Strengthening One Stop Crisis Management Centers (OCMCs) in hospitals • Ensuring GESI responsive planning, budgeting and health service delivery
6	Local Government Operation Act 2017	The Act vows to implement the authority granted to the local level by the constitution by promoting partnership, coexistence, and coordination among the federal, provincial, and local levels to ensure the extension of participatory, accountable, transparent, accessible, and quality services to the general public. Under the Duty, Responsibility, and Authority of the Rural Municipality and Municipality, the Act defines a wide range of health-related activities that the local levels are supposed to undertake. The activities include determination of health-related targets and quality as per the federal and provincial target and standards registration, operation, approval, and monitoring of general hospital, nursing home and health clinics; local level production, processing and distribution of medical plants and herbs, management of social security programs, such as medical insurance, fixation of the minimum price of medicines and other medical production produced at the local level, purchasing, storage and distribution of medicines and medical equipment at a local level and management of health information system at a local level.
7	The Labor Act, 2017	The Act is a key document governing the regulatory framework for labor in Nepal and ensures non-discrimination in employment and

Table 4: Applicable National Legislative Measures, Policy Guidelines and Directives (Social)		
S.N.	**Policies/Acts**	**Descriptions of Measures**
		remuneration and establishes minimum wage level. It bars employers to employ workers without a contract and incorporates provisions of public holidays, annual leave, and maternity and paternity leave. As per the law, the employer is obliged to prepare and implement an Occupational Health and Safety Policy and requires the formation of a Health and Safety Committee if the number of workers is more than 20. Similarly, the Act and its rule also ensure an adequate supply of clean and fresh air and light, provision of separate modern toilets for male and female workers and employees, the supply of safe drinking water, provision of appropriate ventilation, lighting, temperature and sound, measures to protect from dust, smoke, fumes and other impurities, and provision of extinguishing a fire.
8	The Good Governance (Management and Operation) Act, 2064 (2008)	Equity and inclusiveness are regarded as one of the bases for executing administrative function. The Act also requires the Government of Nepal (GoN) to pursue social justice, empowerment of women and promotion of gender justice, uplifting of ethnic groups, Dalit, economically and socially backward classes, sustainable and efficient management of natural and public resources and environmental management while carrying out the administrative function of the country.
9	Disaster Risk Reduction and Management Act 2015	The Natural Calamity Act (1977) was revised to Disaster Risk Reduction and Management Act 2015 to address all four phases of the disaster cycle. Moreover, article number 35 in the Constitution of Nepal 2015 states that every citizen shall have the right to free basic health services from the state and no one shall be deprived of emergency services. It also states that every citizen shall have equal access to health services. This holds true even during the time of disaster. The Act requires the establishment of a National Council for Disaster Risk Reduction and Management, chaired by the Prime Minister, to discharge disaster related functions effectively. The Act also requires the Executive Committee, formed under the Act to for the purposes of implementing policies and plans laid down by the Council, to make immediate provision of emergency medical treatment to disaster victims by setting up adequate settings and services in public and private hospitals or health centers. Thus, during any disaster, basic health services (ten services) mandated by the government should not be withheld.
10	The 15th Plan (FY2019/2020–2023/2024)	The Plan has adopted three objectives to achieve its goal of ensuring access to quality health services at the people's level by developing and expanding a strong health system at all levels. • To achieve balanced development and expansion of all sorts of health services at the federal, provincial, and local levels. • To transform the profit-oriented health sector gradually into a service-oriented sector by increasing government responsibilities and effective regulation for easily accessible and quality health service. • To promote a healthy lifestyle by making health service providers and service seekers more responsible for increasing the citizens' access to health service through multi-sectoral coordination and partnership. The plan envisages establishing and operating at least one basic health service centre in every ward of the local level, at least one primary

Table 4: Applicable National Legislative Measures, Policy Guidelines and Directives (Social)		
S.N.	**Policies/Acts**	**Descriptions of Measures**
		hospital capable of providing basic emergency operation and primary trauma care in every local level, a secondary level hospital, provincial hospital, and a highly specialized hospital under each province and at least a highly specialized hospital and academy of health science in every province under the authority of federal level.
11	Right to Information Act, 2007	To make the functions of the government transparent under democratic system of governance, information plays a very important role. Accordingly, the Right to Information Act has been enacted to allow Nepali citizens' access to information on the functioning of any 'public body' to make governance and policymaking more transparent and accountable. More specifically, Clause 3 of the Act ensures the right to information to all the nationals of Nepal, Clause 7 describes the procedure for acquiring information. Clause 4 of the same describes the responsibility of the public bodies to disseminate information. In doing so, the Act mentions that public bodies may use different national languages and mass media while publishing, broadcasting, or making information public.
12	The Sexual Harassment at Workplace Prevention Act, 2015 (2071)	The Act is a specific legislation addressing sexual harassment at workplace with the objective to protect the right of every individual to work in a safe environment. Under the Act "workplace" is defined to include any place used by (a) government entities, (b) entities owned (fully or partly) by government, (c) corporate bodies or institutions established in accordance with the prevailing laws; and (d) any firm, institution or corporate body registered or licensed to carry out any business, trade, or provide services, while conducting their business. Section 12 of the Act provides that any person who has committed sexual harassment under the Act may be punished with imprisonment of up to 6 months, and/or fine of up to Nepalese Rupees 50,000.
13	Caste-based Discrimination and Untouchability Act, 2011	The Act has made any practices of discrimination and untouchability at both private and public places a crime, and punishable according to the law. The law has increased punishments for public officials found responsible of discrimination. Further, it also requires perpetrators to provide compensation to victims and criminalizes incitement for caste-based discrimination.
14	National Gender Equality Policy, 2021	The Policy envisages removing discriminatory barriers to the socio-economic development of women, children and adolescent girls; ending gender-based violence; adopting gender-responsive governance system; and achieving economic empowerment of women. As per the Policy, the government will implement the fundamental rights of women and the relevant laws in an effective manner; conduct social awareness programs; bring about consistency among the federal, provincial and local laws; develop gender-friendly family and society; and enforce the policy of zero-tolerance against gender-based violence. The Policy requires the government to adopt gender-responsive strategies while making policies, plans and laws; empower women to ensure their access to all State bodies; increase the participation of women in income-generating activities; reduce business and social risk in economic activities of women; and ensure their equal representation at the decision-making levels.

Table 4: Applicable National Legislative Measures, Policy Guidelines and Directives (Social)		
S.N.	**Policies/Acts**	**Descriptions of Measures**
15	Gender Equality and Social Inclusion Strategy of the Health Sector, 2018	The GESI Strategy seeks to contribute to the transformation of health sector into a high performing sector. It envisage doing this by: • strengthening the health system to deliver inclusive, quality and accountable health services, and increase the trust and confidence of excluded communities in them. • mainstreaming GESI into the forefront of health policy, leadership and management, institutional structures and systems of the federal, provincial and local levels of government and their diverse constituencies. • building the capacity of government at the local levels to lead, coordinate and facilitate GESI and be held accountable for GESI results. • Ensuring protective, distributive, and rehabilitative justice to communities left behind by the sector through equitable and inclusive access to quality health services that are accountable for meeting their essential health needs. • empowering target communities to use their health-related rights to demand accessible, GESI friendly and accountable quality health services.
	National Gender Equality Policy, 2021	The Policy envisages achieving social, political and economic empowerment of women by establishing equality among women, men and gender/sexual minorities in terms of legal provisions and practice. To achieve this, the Policy has adopted four objectives: • To provide policies and structures for the socio-economic development of women, girls and children; • To establish a society based on gender equality, values, and norms by ending all forms of gender-based discriminations, violence and exploitation; • To establish gender responsive governance system; and • To achieve economic empowerment of women.
16	Land Acquisition Act (1977) and Land Acquisition, Resettlement and Rehabilitation Policy for Infrastructure Development Projects (2015)	These key legal instruments specify procedures to be followed for land acquisition and compensation. The legal instruments empower the Government of Nepal to acquire any land, against payment of compensation, for public purposes or for the operation of any development project initiated by government institutions. They also include a provision for acquisition of land through negotiations. Clause 27 of the act includes provisions for land acquisition through negotiation with the plot owners, where the process of land acquisition is not required. The policy enables voluntary donations, direct negotiation, land development programs, and use of eminent domain. In general, most construction of health facility buildings and associated facilities is expected to take place within its premises. And if land is required, it will be through voluntary land donations by the communities. In exceptional cases, a willing seller, willing buyer approach may apply as provided in the Land Administration Act and Land Revenue Act. The program will not entail any involuntary land acquisition through eminent domain.
16	International Laws and Conventions	Nepal is the State Party of ILO Convention on Indigenous and Tribal Peoples, 1989 (No.169). The convention requires consultation with the peoples concerned through appropriate procedures and, in particular,

Table 4: Applicable National Legislative Measures, Policy Guidelines and Directives (Social)		
S.N.	**Policies/Acts**	**Descriptions of Measures**
		through their representative institutions, whenever consideration is being given to legislative or administrative measures, which may affect them directly. It further states that indigenous and tribal peoples shall, wherever possible, participate in the benefits of natural resource utilization activities and shall receive fair compensation for any damages, which they may sustain as a result of such activities. The convention also further explains regarding relocation, which has clearly stated that during this process free and informed consent of indigenous people, must be taken.
		Nepal is party to many international conventions that directly or indirectly relate to the issue of disability. South Asian Association for Regional Cooperation (SAARC) declared 1993–2002 as the SAARC Decade for the Disabled.
		In addition, Nepal is committed to important international conventions which have strong gender implications such as United Nations Millennium Declaration, the Beijing Platform for Action, and the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW).

62. The applicable national legislative measures, policy guidelines and directives related to the environment are presented in the table below (Table 5).

Table 5: Applicable National Legislative Measures, Policy Guidelines & Directives (Environmental)		
S.N.	**Policies/Acts**	**Provision**
1	Constitution of Nepal, 2015	Right to clean environment is listed as the fundamental right of every citizen by the Constitution of Nepal.
		Part 3: Fundamental Rights and Duties: Right to clean environment: Article 30 states: (1) every citizen shall have the right to live in a clean and healthy environment. (2) The victim shall have the right to obtain compensation, in accordance with law, for any injury caused from environmental pollution or degradation. (3) This Article shall not be deemed to prevent the making of necessary legal provisions for a proper balance between the environment and development, in development works of the nation.
		Article (221), has given legislative power to the local level - the village and the municipal assembly. In the current federal context, based on the constitutional legislative power (schedule 6, 7 and 9), the provincial and local governments are mandated to prepare and publish their own legal framework.
2	Public Health Service Act, 2018	The Section 41 of the Act entitled "Sanitation and Waste Management has provided for the following: (1) The Government of Nepal may, to control or cause to be controlled the adverse effect to the human health by environmental pollution and waste, make necessary standards in accordance with the prevailing Federal law. (2) The Government of Nepal shall make necessary standards for collecting, reusing, refining, disposing, and regulating the health friendly waste. (3) It shall be the duty of the Provincial and Local Level to comply with the standards referred to in sub-section (1) and (2). (4) Each health institution shall manage the risk-

Table 5: Applicable National Legislative Measures, Policy Guidelines & Directives (Environmental)		
S.N.	**Policies/Acts**	**Provision**
		free and risky waste by separating them pursuant to the prescribed standards. (5) Each health institution shall provide the service providers with clean drinking water pursuant to the prescribed standards.
	Public Health Service Regulations 2020	The recently approved Public Health Service Regulations 2020,Schedule 8 provisions to develop health Institution Operation Standards of related to management of health-related and other waste under which MOHP developed National Healthcare Waste Management Standards and Operating Procedures 2020 which discourages open incineration of waste and strongly recommending autoclaves and other non-burning, environment-friendly technologies, which do not generate GHG emissions.
3	Environment Protection Act, 2019 and Environmental Protection Rules, 2020	Environment Protection Act (EPA) 2019 and Environmental Protection Rules (EPR) 2020 are the major legislations that provide a holistic framework for the protection, management, and improvement of the environment during project implementation. The EPR, 2020 highlights that any development project, before its implementation must undergo an environmental assessment, which will be in the form of either a Brief Environmental Study (BES), Initial Environmental Examination (IEE), or Environmental and Impact Assessment (EIA) depending upon the location, type, and size of the project. The EPA requires Strategic Environmental Analysis (SEA), which will allow policymakers to systematically evaluate the environmental, social, cultural and economic impacts of proposed projects, programs or policies and in-depth alternative analysis which mandates that project proponents compile information on the favourable and adverse environmental impacts of all credible alternatives for the proposed project, and recommend the most appropriate alternative for implementation etc. The Act has incorporated provisions relating to climate change to promote adaptation and mitigation of climate change at all three tiers of government. The Act also requires the involvement of the project communities/stakeholders in the stages of preparation of BES, IEE and EIA in a prescribed manner. Provisions for submission of a proposal for approval and conditions of approval are provided in the Act.
4	National Environmental Policy, 2019	The Government of Nepal (GoN) endorsed the Policy to control pollution, manage waste and promote greenery to ensure citizens' right to live in a fair and healthy environment. The Policy guides the implementation of environment related laws and other thematic laws, uphold international commitments and enables collaboration between all concerned government agencies and non-government organizations on environmental management actions.
5	Climate Change Policy, 2019	The Policy includes climate adaptation and disaster risk reduction; low carbon emission and climate resilience; access to financial resources and utilization; capacity building, peoples' participation, and empowerment; study, research, technology transfer; climate-friendly natural resources management; and institutional set up with legal provisions for monitoring and evaluation.
6	Nepal Health	The NHS-SP 2022-32 focuses on developing multi-hazard-resistant

Table 5: Applicable National Legislative Measures, Policy Guidelines & Directives (Environmental)		
S.N.	**Policies/Acts**	**Provision**
	Sector – Strategic Plan, 2022-2032	infrastructure by adapting green technology as one of the means to achieve Outcome 1.3: Safe and people friendly health infrastructures. It also calls for developing guidelines for quantification, forecasting, and disposal of pharmaceutical and diagnostic waste for attainment of Outcome 1.4: Ensured uninterrupted availability of quality medicine and supplies.
7	Minimum Service Standards, Checklist to Identify Gaps in Quality Improvement in Primary Hospitals, MoHP, 2018	This document focuses specifically on primary hospitals with general services, primary hospitals with specialized services, secondary hospitals, tertiary hospitals, and health posts. These standards cover a range of issues for health care facilities; "hospital waste management" is clearly addressed under the section called "Hospital Support Services," with a checklist for evaluating a hospital's waste management system, including a scoring system for the segregation, collection and transportation, treatment, and disposal of waste for the different levels of healthcare facilities.
8	15th. Five Year Plan, 2019/20-2023/24	The Fifteenth Five Year Plan promotes clean, healthy, and green environment. This can be achieved by setting the goal of pollution control, waste management and plantation of the tree to ensure the right to clean and healthy environment. Management of all kinds of waste generating from health facility including household, industry has remained under the prime objective of this plan.
9	Forestry Policy (2015)	The GoN has promulgated Forest Policy 2015 by repealing previous policy of 2000.All forest sector policies and strategies including forest, wetland, vegetation, wildlife, biodiversity, Non-Timber Forest Product (NTFP) and soil and watershed conservation are directed by this policy. "Forest, biodiversity, plants resources, wildlife, watersheds and other ecosystems are protected, sustainably managed and climate resilient through an inclusive, decentralized, competitive and well-governed forestry sector providing equitable employment, incomes and livelihoods opportunities" is the goal of this policy. This policy, among others, emphasizes enhancing climate resilience capacity of the society and forest ecosystems. It promoted payment for ecosystem services (PES) and biomass based renewable energy. This policy further emphasizes diversification and optimum utilization of forest products and services. Central to this policy is to manage and utilize land and forest resources according to their ecological advantage. It includes protection of land from degradation by soil erosion, landslides, desertification, and other ecological disturbances.
10	Local Government Operations Act, 2017	The Act defines the roles, responsibilities and authorities of the local governments. The Act was enacted as per Article 296 (1) of the Nepal Constitution 2015 to leverage local leadership and the governance system. The Act has stipulated several arrangements related to authorities, duties and responsibilities of local government, assembly meeting and working system, assembly management procedures, plan formulation and implementation, judicial works, financial jurisdictions, administrative structure, and district assembly, among others. It outlines criteria to divide a state into municipalities or rural municipalities and respective rights, duties and responsibilities in different development and

Table 5: Applicable National Legislative Measures, Policy Guidelines & Directives (Environmental)		
S.N.	**Policies/Acts**	**Provision**
		conservation sectors. It clarifies the rights of municipalities/rural municipalities to form local laws, regulations, and criteria for conservation of environment protected areas and species; for environmental pollution and hazard control; solid waste management and so on.
11	Solid Waste Management Act, 2011	The Act focuses on sustainable management of solid waste and minimizing negative impacts on the environment and public health. Chapter (2) Sub Section (7.2) outlines that any individual, organization or body producing harmful or chemical waste shall be responsible for the management of such waste as prescribed. Chapter (9) Section (38) has provision of "Offense and Punishment" where anyone is found to be committing acts deemed offensive will be liable to a fine imposed by the local body under Section 38 paragraph (j) ranging from NPR 30,000 to NPR 50,000. The offensive acts according to Section (38) Sub-section (J) are as follows: throwing, placing, depositing, or discharging any kind of harmful waste, except in places prescribed by the local body like a road or on any other public places, causing detrimental effect to public health.
12	Drinking Water Regulation, 1998	The Regulation specifically deals with drinking water and sanitation issues. Among other provisions, this Regulation regulates the quality of drinking water and drinking water suppliers.
13	The National Building Code, (NBC) 105 (2020)	This Code covers the requirements for seismic analysis and design of various building structures to be constructed in the territory of the Federal Republic of Nepal. The Code also makes it mandatory to follow the minimum standards for design of earthquake resistant buildings with structures or components thereof to be determined in accordance with the provisions of this standard. The NBC requires that building structure shall be designed and constructed to withstand the design seismic forces without local or global failure that, thus retaining its structural integrity, stability against overturning and a residual load bearing capacity after the earthquake.
14	Standard Guidelines for Post-Disaster Reconstruction of Health Buildings: GoN, Ministry of MoHP, 2015	These standards, developed by the Ministry, included the requirements for health infrastructure to include aspects such as waste management plans, circulation network, sites for bins, design for placenta pits, water points for drinking water and hand-washing, types of signs etc. It also incorporated aspects related to accessibility for people with disability, road connectivity etc.; and guidelines for disinfection and disposal of infectious and chemical liquid waste including designs for septic tanks, soak pits, ramps, lifts, doors, toilets and other details.

2.03 World Bank's Country Partnership Framework 2019–2023

63. The proposed PforR is aligned with the World Bank Group's Nepal Country Partnership Framework (CPF) 2019–2024[18]and the thematic shifts identified in the Program Learning Review

[18]It will contribute directly to three CPF objectives under two focus areas: 'Strengthened institutions for public sector management and service delivery' (Objective 1.2) under the first focus area, Public Institutions, and 'Improved access to services and support for the well-being of the vulnerable groups' (Objective 3.2) and 'Increased resilience to health shocks, natural disasters, and climate change' (Objective 3.3) under the third focus area, Inclusion and Resilience.

(PLR; 2022), particularly to (i) pivoting to Green, Inclusive and Resilient Development (GRID) approach, by boosting resilience through health systems strengthening and emergency preparedness, and by promoting inclusion of poor and vulnerable through increased financial protection while accessing healthcare; and (ii) harnessing digital development, by introducing and/or expanding digital solutions to strengthen health data systems, increase the use of data for decision-making, and institutionalize efficient management of essential medical equipment, thereby leading to improved quality of healthcare.

64. In September 2021, the World Bank joined hands with the government of Nepal and development partners to endorse the landmark 'Kathmandu Declaration' for a strategic action plan for green, resilient, and inclusive development (GRID) of Nepal to systematically address the impacts of COVID-19 and the country's structural challenges. The GRID approach involves a fundamental shift in managing risk and development: from a reactive response to a deliberate and proactive recovery strategy for long-term green growth, climate action, and sustainable and inclusive development for all.

65. The NQHSP focuses on enhancing equity through more nuanced targeting of poor and vulnerable and out of reach populations and improving quality of the public healthcare system. It also focuses on enhancing health emergency preparedness and response capacity at sub-national levels by improving the preparedness, planning, surveillance and rapid response capacity. Thus, the proposed PforR contributes towards the World Bank Group (WBG) Nepal's Partnership Framework: Objective 3.2 "Improved access to services and support for the well-being of the vulnerable groups" and Objective 3.3 "Increased resilience to health shocks, natural disasters, and climate change" under the "Focus Area 3: Inclusion and Resilience".

2.05 Borrower's Past Experience in Handling Environment and Social Aspects

66. The MoHP and DoHS have long experience in providing health service to the general public. Over the years, the MoHP provided able leadership to the health sector in terms of provision of policies, coordination with other relevant line agencies and oversight including for environmental and social risk management. Important policies, strategies and guidelines[19] along with institutional structures and mechanism are in place to address environmental and social issues.

67. DoHS has provided guidance, annual plans/program, monitoring, and supervision for all countrywide health sector programs implemented in the past. In the current federal set-up, community health workers and primary health care centers (PHCC) that include a network of health outreach units fall under the jurisdiction of municipalities. Secondary-level health care facilities, including former district and provincial hospitals, come under the jurisdiction of provincial governments while tertiary-level health care facilities, also comprising specialized hospitals, fall under the jurisdiction of the federal government. Previously, all four tiers of healthcare were the responsibilities of the central government. Only in recent times, sub-national governments have been engaged in providing health related policy guidance and services in accordance with exclusive and concurrent rights granted by the new Constitution to the three levels of government. Thus, at the institutional level, provincial and local governments, have little institutional experience at providing leadership to the healthcare sector, including in the exercise of guidance and oversight related to implementation of E&S safeguards measures.

[19] Such as Public Health Service Regulations 2020; National Healthcare Waste Management Standards & Operating Procedures, 2020; Minimum Service Standards, Checklist to Identify Gaps in Quality Improvement in Primary Hospitals, MoHP, 2018; Gender Equality and Social Inclusion Strategy of the Health Sector, 2018, including the new GESI strategy that awaits cabinet approval

2.03 E&S risk management Planning and Management Procedures

68. The regulatory provisions related to environmental and social E&S risk management procedures in the health sector exists but is not adequate. The Public Health Service Act, aims to guarantee the right of the citizens to get free basic health service and emergency health by establishing access to regular, effective, qualitative, and easily available health services. The Health Policy, 2019 focuses on developing and expanding a health system for all citizens in the federal structure based on social justice and good governance and to ensure access to and utilization of quality health services. Further, the Policy has provisions for making specialized services easily accessible through health insurance which aims to: i) strengthen and integrate into the insurance system treatment of services that are not included in basic health services; ii) link poor and prioritized target group with sate subsidized health insurance system based on the principles of social justice; and iii) provisions for management for HCWM, WASH and infection control.

69. The GoN's legal and policy framework as well as the political commitments to gender and social inclusion have laid down the ground work for addressing gender and social exclusion issues in the health sector and integrating GESI into systems and services. The approach is to ensure that all vulnerable groups are consulted and benefit from Government's health sector programs. MoHP's programs are guided by periodic Gender Equality and Social Inclusion Strategies. The GESI Strategy, 2018 is focused on: i) mainstreaming GESI in the Health Sector policies, strategies, system, plans, programs, budget and monitoring and evaluation of the federal, provincial and local governments; ii) integrating GESI to promote equitable access of health services by increasing targeted communities' access to and utilization of basic health services; and iii) implementing programs that cater to the needs of vulnerable and marginalized citizens so as to ensure their access to and utilization of health services. It envisages doing this by improving the quality of basic health services as a means for enahancing the access and utlization of targeted groups to health servcies and instutionalizing/activating systems and structures for GESI mainstreaming in the health sector's policies, stratgies, plans, program, and budgets of national and sub-national governments. The startegy calls for adopting positive measures for increasing the availability, access and utilization of basic health services by targted groups. This, among others, include: i) formulating and implementing health program as per the needs of targeted groups particularly the needs of marginalized and vulnerable groups; ii) enhancing the accoutability of health service providers/actors; iii) sensitizing and empowering targeted groups so as to enable them to acccess health service; iv) promoting collaborations and partnership for GESI mainstreaming; v) analysing and conducting audit of basic health service from the GESI perspective; and vi) promoting collaboration and partnership for the delivery of GESI responsive health services. From the social safeguards perspective, these provisions in MoHP's GESI Strategy are in line with the results and sub-results the NQHSP intends to achieve. Thus, there arises a need for effective roll out and implementation of the GESI strategy at the national and sub-national levels. In recent times, MoHP's GESI strategy has been further revised and update. The latest version is likely to be approved by the cabinet in the near future.

70. MOHP also has also rolled out Gender Responsive Budgeting Guideline for the Health Sector, 2019 for undertaking gender responsive budgeting in the health sector to achieve the Government’s gender equality and health objectives. Gender classification of budget lines in Line Ministry Budget Information System (LMBIS) has also been applied since fiscal year 2009/10. However, the institutional environment, human resource capacity and system requirements to underpin gender responsive budget formulation needs strengthening. The MoHP has put into force the ‘Annual Plan and Budget Formulation in the Health Sector at the Local Level Guidelines, 2018 ’to coordinate and facilitate the formulation of plan and budget in the health sector at the local level and to harmonize

the planning and budgeting functions at different levels. However, this directive has not included provision for gender analysis or gender responsive budgeting. In addition, the lack of technical GRB capacity, the lack of sex-disaggregated data and the absence of an enabling environment are bottlenecks for the application of GRB at the local level.[20]

71. The MSS checklist that assesses health facilities compliance with minimum quality standards is designed to identify gaps in primary hospitals for the improvement in quality of health service delivery encompasses a range of environmental safeguards measures that health facilities must comply with including a scoring system for the segregation, collection and transportation, treatment, and disposal of waste for the different levels of healthcare facilities.

72. The National Council for Disaster Risk Reduction and Management, chaired by the Prime Minister, has been established to discharge disaster related functions effectively. An Executive Committee has been formed under for the purposes of implementing policies and plans laid down by the Council, to make immediate provision of emergency medical treatment to disaster victims by setting up adequate settings and services in public and private hospitals or health centers. Thus, during any disaster, basic health services mandated by the government should not be withheld which requires effective systems for disaster preparedness and response. The NHQSP is designed to further strengthen the governments' preparedness and response systems.

73. The MoHP has also formulated and applied Environmental and Social Management Frameworks (ESMF) for E&S risk management in its projects/programs implemented in the past. These frameworks identify potential E&S risks and mitigation measures. Moreover, they also delve into healthcare waste management and infectious disease control protocols of other relevant international agencies, particularly the World Health Organization (WHO). The ESMF applied by the MoHP for the COVID-19 Emergency Response and Health System Preparedness Project presents the current medical waste management practices in Nepal along with the potential hazards on the environment and the public health in the context of the COVID-19 pandemic. Furthermore, it analyses the social risks and impacts such as the marginalization of poor and vulnerable people in terms of access to relevant information and healthcare services, management of medical waste on landfills, which may pose a serious threat to community health and safety, and the rise in social tensions due to mandatory isolation and quarantine, and restrictions on transmission amplifying events, such as festivals. The ESMF also prescribes procedures for management of identified E&S risks and impacts, including various measures to raise awareness, knowledge, and understanding among the general population about the risk and impact of the project activities. Additionally, the ESMF proposes a functional GRM system, capable of addressing concerns of local communities through a transparent process that is culturally appropriate and readily accessible to all segments of the affected communities. However, as the ESMFs, applied in the past, are project specific document; there arises a need to formulate and apply an ESMF that encompasses all health sector programs.

74. In recent times, sustainable management of healthcare waste has been accorded priority by the GoN. Nepal has been supported by development partners, such as GIZ, the World Health Organization, UNICEF and the United Nations Development Programme (UNDP), to improve its infrastructure and capabilities in healthcare waste management. A notable initiative in this direction is the two years "Health Care Without Harm" project supported by the GIZ, which works with MoHP

[20] Gender Responsive Budgeting Guideline for the Health Sector, 2019, MoHP

and four major hospitals[21] in Kathmandu valley on health care waste management and capacity-building, and in nine other hospitals out of Kathmandu valley on technical advice and peer learning.

75. Yet despite these initiatives, a more concerted effort needs to be made in the area of sustainable integrated healthcare waste management (including e-waste) which benefits healthcare facilities and the communities they serve. This requires allocation of budget from all the three tiers of Governments for the procurement of necessary equipment and providing training to healthcare practitioners so as to enable HCFs to design and operate HCWM system that adheres to the Standard Operating Procedures for the segregation, collection, transportation, storage, treatment, and final disposal of healthcare waste. Besides, waste handlers should also be given sufficient waste management training, safety equipment, and basic health insurance. In the future, the development of a central healthcare waste management system in the metropolitan and sub-metropolitan cities should be prioritized so that healthcare institutions within their vicinity can benefit. For long-term sustainability, central healthcare waste management system could be run as public-private collaboration as applied in Pokhara and Nepalgunj municipalities.

2.04 Institutional Arrangements and Mandate

76. A dedicated team/secretariat will be assigned by MoHP to facilitate sector coordination and support (including for activities related to the Program and the Bank) with accountability requirements of DPs under the SWAp modality, guided by a Joint Financing Arrangement (JFA)[22] between MOHP and SWAp partners, including the Bank. The institutional arrangement for overseeing safeguards planning, implementation and monitoring/evaluation will be aligned to the Program implementation structure. The MoHP, as the executing agency, will have the overall responsibility for safeguard policy formulation and oversight. DoHS will provide overall guidance to the designated authorities at the provincial and local levels to implement safeguard measures at the HCF level.

77. Thus, in the current context, DoHS will need to play a critical role in safeguard planning, providing orientation on safeguard issues, frameworks, guidelines, and standards to provincial/local governments and HCFs and monitoring compliance. The MoHP has designated a focal person for overseeing safeguards concerns. While DoHS is mainly involved in providing guidelines and coordination, provincial as well as local governments and HCFs are responsible for the implementation of NQHSP including safeguards planning and compliance.

78. The MoHP has established a GESI unit and separate committee/working group for mainstreaming GESI in the health sector in line with the Institutional Structure for Establishment and Operational Guidelines. This includes:

i) **GESI Steering Committee,** at the ministry level, that is responsible for mainstreaming GESI in the health sector and taking the lead role in the institutionalization of GESI in health institutions at federal, provincial, and local levels. The Chief of the Population Division functions as the GESI Focal Person for the entire MoHP.
ii) **GESI Technical Working Groups (TWGs)** are responsible for implementing GESI-related activities and mainstream GESI in the divisional programs.

[21]On June 10, 2022, four hospitals (National Academy of Medical Sciences - Bir Hospitals, Patan Academy of Health Sciences - Patan Hospital, Shukraraj Tropical and Infectious Disease Hospital Teku, and the Nepal Armed Police Hospital) signed a Memorandum of Understanding (MoU) to signal their commitment to the project.

[22] JFA is an agreed strategic framework for harmonized implementation of the sector program, under Nepal's health SWAp, signed by the Secretaries of Ministry of Finance and MOHP, and heads of respective organizations.

79. At the MoHP, a program implementation committee, headed by the Project Coordinator who is the Chief Specialist of the Health Coordination Division, was formed for the implementation of the COVID-19 Emergency Response and Health System Preparedness Project. The Committee will coordinate and exercise oversight on the overall activities related to environmental and social activities envisaged by the ESMF until the project closure and transfer for management to the designated authority. Besides this committee, technical working groups (TWGs) were formed for the purpose of advising and knowledge sharing among the experts on thematic areas. Formation of an appropriate implementation structure and giving continuity to TWGs will also be important for the implementation of NQHSP.

80. In principle, the Health Facility Operation and Management Committee (HFOMC) is responsible to oversee the implementation of the E&S measures under the technical supervision of the Implementing Agency (IA). The IA is responsible for appointing a safeguard focal person to look after safeguards implementation. The key environmental and social tasks, corresponding activities and responsible units that can be applied by the NQHSP are as follows:

Table 6: Key Environmental and Social Tasks, the Corresponding Activities and Responsible Units

S.N.	Key Environmental & Social Tasks	Activities	Responsible Unit
1	Overall Environmental and Social Management Framework (ESMF) planning and implementation	Training/orientation/consultations and development of guidelines	Project Implementation Unit, Ministry of Health and Population (MoHP)/Department of Health Services &Provincial/Local Governments (LGs)
2	Activity level Environmental & Social (E&S)screening, risk assessment and categorization	Desk study/walkthrough/ meetings/ consultations	LGs/healthcare facilities under the guidance of Program Coordination Unit (PCU)/DoHS
3	Preparation of activity levelEnvironment and Social Management Plans (ESMPs)	Desk study/site visit/ survey/ preparation of document and consultations	Provincial/local governments/healthcare facilities with support of PCU/DoHS
4	Implementation of ESMPs and other E&S management plans	▪ Mitigate and manage the environmental and social risks/impacts ▪ Compliance monitoring ▪ Ensure benefits to the target groups	Provincial & local governments, healthcare facilities & contractor

81. Tertiary-level, secondary-level and primary–level public health care facilities are responsible for implementing facility specific E&S safeguards measures under the government healthcare system. The MoHP/DoHS support them by providing guidelines/standards, budget, safeguard related equipment and technical assistance for development of human resource and upkeep and operation of equipment. The MoHP/DoHS are also responsible for monitoring and supervision of the implementation of safeguard measures in health facilities under the jurisdiction of all three tiers of government. At the sub-national level, the Ministry of Health of the Provincial Government and Municipalities are responsible for overseeing implementation of E&S safeguards measures in healthcare facilities under their jurisdiction.

2.04 Institutional Capacity of Relevant Agencies in Identifying and Managing

82. The federal level regulatory framework for identifying and managing E&S issues is strong both in terms of provisions for creating a safe environment for healthcare facilities and safeguarding the environmental hazards such as pollution, waste management and natural disasters. However, the implementation of these existing legal and regulatory provisions, at the provincial and local levels, faces challenge due to regulatory deficiencies, shortage of human resource, inadequate institutional capacity and low priority and budget allocation.

83. MoHP has the policies and plans and trained human resource and budget for identifying and managing E&S issues. The institutional capacity to provide policy guidance and exercise oversight is strong. A similar situation is also prevalent in the DoHS in terms of policies and plans and trained human resource and budget. The institutional capacity of MoHP in terms of policy implementation, monitoring, capacity development of human resource as well as providing guidelines and orientation on E&S safeguards and operation of HMIS is strong.

84. However, the institutional capacities at the provincial and local levels are inadequate and require strengthening. Furthermore, there is lack of clarity on the roles and responsibilities for carrying out E&S related activities like screening, preparing ESMPs and monitoring. Though all Provincial Governments have formulated their Environment Protection Act, they lack policies, adequate human resource, and budget to carry out the defined responsibilities under the applicable system particularly in terms of providing policy guidance and exercising oversight.

85. LGs, in general, lack policies, guidelines and adequate human resource and budget to carry out the defined responsibilities under the applicable system particularly in terms of implementation and monitoring of safeguard measures in HCFs. LGs are mostly using the Health Facilities Establishment, Operation and Upgradation Guideline and National Building Code for post-earthquake health facility construction. They are not directly applying the ESMF and many are not aware of the framework of the MoHP. It is not surprising that supervision and inspection of healthcare facilities including application of safeguard measures has not yet been institutionalized. Most of the HCFs have formed GRM Committees or appointed focal person for dealing with grievances which are filed through complaint boxes or verbally reported to the GRM focal person.

86. Recognizing the capacity lapses, development partners, such as the GIZ, are currently providing support (including training and equipment for staff) to help strengthen health care waste management system in hub hospitals. Similarly, UNICEF, WHO and other partners are supporting the MoHP with community engagement and risk communications works while the WB project is filling the financing gap.

2.05 Sub-national Governments in the Health Sector

87. The Constitution of Nepal has broadly defined the exclusive and concurrent mandates of the three tiers of governments, including for health related policies and services. However, specific accountability and responsibility related to the health sector are not articulated in the Constitution. Two documents help clarify this. The Functional Analysis and Assignment (FAA) specifies mandates/functions across the three levels of government. The Local Government Operation Act defines roles, responsibilities, and rights of local government. With the change in the governing system, the provincial government has established its own Ministry of Health and all the LGs have setup their own health units.

88. The functions of the provincial governments are mostly related to establishing provincial policies, laws, and standards; management of health services and the provincial level; and regulating provincial level health institutions. Similarly, the functions of local governments are mostly related to the formulation of policies, laws and standards for basic health, sanitation, and nutrition along with management of different components of basic health including blood transfusion services and hospital operation.

89. Though no specific human resource management related functions are provisioned for local governments, LGOA has made some important provisions in relation to the overall management of human resources. As per the LOGA, provincial governments are mandated to manage the recruitment process as well as define the salary scale for the local level health employees. Local levels, however, are authorized to propose the number of permanent positions based on the local need and financing capacity. For the purpose of harmonization, according to the LGOA, the fundamental principles and standards regarding the establishment, operation and management and terms/conditions of the local service shall be as per the federal law. Harmonization of provincial and local services norms/standards with the federal government has been done.

2.05 System Performance

90. This sub-section examines system performance at the policy, regulatory as well as the operational level. At the regulatory level, a review of the performance of the regulatory functions of various relevant agencies has been presented. At the operational level, a review of the performance of safeguards planning and implementation at the three levels of the federal structure has been presented.

Environmental Mitigation Measures

Environmental and Social Screening

91. Given that environmental and social screening practices for activities related to healthcare programs are relatively new, a long-term national level planning framework or guidelines to guide the screening works is yet to be formulated/applied. For projects financed by World bank, the project/program adhere to the framework prepared by the project. Screening procedures were adopted for, NHSP-II and Nepal Emergency COVID -19 project to identify potential social and environmental issues or impacts during the planning and design stage of the project and determine the instrument like ESMP and ICWMP for addressing the issues.

Environmental and Social Compliance Monitoring

92. MoHP/DoHS are primarily responsible for E&S compliance monitoring. The healthcare facilities are responsible for regular monitoring, preparation of ESMPs, and compliance of ESMPs. The Nepal Health Facility Survey 2021 provides valuable insight to decision-makers on the state of health facilities in relation to service quality and service readiness. In general, a program/project implementation unit, which will be responsible for monitoring program/project activities including E&S compliance, is formed by the MoHP. Compliance monitoring of E&S safeguards requirements was considered as weak by all stakeholders consulted by the ESSA team, particularly at the sub-national level. Lack of dedicated human resource and inadequate budget outlay for this task along with low priority accorded to this aspect was cited as the major reasons for weak E&S compliance monitoring. Thus, E&S safeguards compliance monitoring has yet to be institutionalized, as a regular practice, in health service-related entities across all three tiers of governments.

Health care waste management

93. On the policy reform, the recently approved Public Health Service Regulations 2020 and National Healthcare Waste Management Standards and Operating Procedures 2020 will address the HCWM hazards by strongly discouraging open incineration of waste and strongly recommending autoclaves and other non-burning, environment-friendly technologies, which do not generate GHG emissions, in line with World Health Organization guidance. The Standards and Operating Procedures also emphasize the need to formulate safe healthcare waste management guidelines for provincial and local governments. By encouraging emission free waste management methods, the action will lead to climate change mitigation in the health care sector through investments in autoclaves and other measures to replace the GHG-emitting burning practices starting with central and regional hospitals. Although the main waste disposal is incineration, the use of autoclave is prevalent in bigger hospitals and health centers. In recent times, the use of autoclave, which sterilizes waste with a very hot and high- pressure steam, has been steadily increasing in health facilities in Nepal.

94. The Minimum Service Standards, Checklist to Identify Gaps in Quality Improvement in Primary Hospitals, MoHP, 2018 covers a range of issues for health care facilities. "Hospital waste management" is clearly addressed under the section entitled "Hospital Support Services," with a checklist for evaluating hospital's waste management system, including a scoring system for the segregation, collection and transportation, treatment, and disposal of waste for different levels of healthcare facilities. Given that the Program focuses on expediting the reforms to improve health facility readiness for quality healthcare at all public sector health facilities, proper management of HCW in line with the MSS is also important to improve provision of health services. The Nepal Health Sector - Strategic Plan 2022-2032 under the Strategic objective 4. "Promote equitable access to quality health services" commits on reinforcing implementation of infection prevention and health care waste management standards.

95. A large quantity of e-waste can be generated when medical equipment become obsolete, non-functional or are replaced by new ones. During COVID-19 response, there was a large influx of medical equipment, mostly donated, with many ending up in hospitals and smaller facilities with little or no capacity to operate and maintain, and many of these might pass their lifetime without being used. Thus, maintenance leading to management of e-waste poses new challenges in the days to come. Further, inadequate institutional capacity of sub-national governments, in terms of human resources for maintenance of equipment, budget and policies, is likely to adversely impact their oversight functions over healthcare facilities resulting in inaction due to low uptake of the MSS data.

96. While Nepal has made great progress in expanding access to water and sanitation, the country faces significant challenges in proper management of health care waste (HCW),[23] particularly in metropolitan and sub-metropolitan areas and densely populated municipalities. For instance, in recent times, the management of additional volume of infectious waste (including sharps generated during vaccination) was a major challenge. There is a lack of dedicated HCWM personnel, standard equipment and infrastructure and resources for operation and maintenance of equipment, which is further aggravated by unclear roles and responsibilities of sectoral actors involved in HCWM. There is also a need to change perceptions and attitude of healthcare workers for waste segregations and to adopt environment friendly technologies for the treatment and disposal of HCW at all levels. There is also the issue of liquid waste management in hospitals which is often untreated and directly disposed into the public sewage system.

[23]No Time To Waste, Transforming Healthcare Waste Management for a Healthier, more Sustainable Nepal, GIZ (www.giz.de/Nepal)

Social Mitigation Measures

97. **Enhanced access and quality of healthcare:** Constitutional and legal provisions together with healthcare policies, guidelines, and frameworks mandate of MoHP, provincial governments and LGs to improve nationwide access, equity and quality in health services. The National Health Policy, 2019 is guided by the principles of: i) special health services targeted to marginalized, Dalit and indigenous communities; and ii) diversification of equitable health insurance.

98. **Improvement in effectiveness and equity of healthcare:** The program is designed to improve the effectiveness and equity of healthcare through two measures.

99. **Focus on both the demand and supply side of National Health Insurance:** The Program focuses on increased and sustained coverage of health insurance particularly among poor and vulnerable population, while pursuing institutional and digital reforms to strengthen the insurance system. Targeting mechanisms and mobilization strategies to be deployed by local levels to identify and enroll poor and vulnerable households into the insurance program will be defined and implemented in the interim until the identification of ultra-poor households by other GoN ministries is completed in all districts.

100. **Strengthening local capacity for health planning, budgeting, execution, and monitoring:** Local levels in the two selected provinces will be supported with measures to build their institutional capacity and leadership in prioritizing and developing their health sector plans using data and evidence. This will not only increase the efficiency of the local health system but is also expected to enhance equity through more nuanced targeting of poor and vulnerable and out of reach populations.

Integrated services to survivors of GBV

101. The Ministry of Health and Population (MoHP) provides integrated services to survivors of GBV by establishing hospital based One-stop Crisis Management Centers (OCMCs). OCMCs provide free hospital-based health services including identification of survivors, treatment, psychosocial counseling and medico-legal services, and coordinate with multi-sectoral agencies that provide survivors access to safe homes, legal protection, personal security and rehabilitation. They also refer clients for specialist health services as required.

102. Many doctors and staff nurses have received GBV and OCMC training in line with Standard and Guidelines on the Clinical Protocol and OCMC Manual (2016). This has received widespread support from doctors and nurses which has increased their sense of responsibility to GBV survivors. Similarly, staff nurses who received psychosocial counseling training have been reported to become more sensitive to survivors needs and show respect and empathy. Despite the rollout of training, this has not covered all OCMC staff and capacity gaps persist. High staff turnover contributes to the challenge. Further, the transition to federalism has impacted budget allocations for OCMCs. Federal hospitals receive funding direct from MoHP, while the conditional grant funds for others are sent via the province and have suffered from delays and incompleteness.[24]

The Health Insurance Program

[24]Review of the Scale-up, Functionality, and Utilization including Barriers to One Stop Crisis Management Centres, DoHS 2020

103. This health insurance program aims to improve overall health status of Nepalese citizens by: i) ensuring universal health coverage by increasing access to and utilization of necessary quality health services; ii) increasing the financial protection of the public by promoting pre-payment and risk pooling in the health sector; and iii) improving the effectiveness, efficiency, accountability, and quality of care in the delivery of health care services. It intends doing this by i) increasing participation of communities towards health insurance program by providing special protection to the poor and marginalized; and ii) extending coordination and cooperation with government and nongovernment service provider health institutions for gradual expansion of health insurance program throughout the country.

104. Though the National Health Scheme started in 2017, there have been implementation challenges in insurance coverage and enrolment, provision of health services, and claims management. At the outset, when the program was initially launched, people were interested in the insurance scheme and the rate of enrolment rapidly increased though it could not be sustained in the years that followed indicating a roll out without adequate preparation. Retaining people enrolled in the insurance scheme has been an issue due to shortage of medicines, laboratory services and health personnel in public health facilities. Lack of or delay in identification of poor people was another issue that impacted enrolment rate. Initiatives have been taken for organizing interaction program with the participation of local bodies, health facility management committee, and local people with the objective of providing information on health insurance and increasing the enrolment rate. However, given these interactions are sporadic, more focused, frequent and large scale stakeholder engagements are necessary for better buy-in of the wider community for enrolment in health insurance schemes. Enrolment has also been adversely impacted as poor people lack the financial means for the membership while rich and educated people are often reluctant to get enrolled since they have the financial means to travel to Kathmandu or other big cities for healthcare and do not need health insurance.[25] Thus, the urgent need for the identification of ultra-poor so that they can receive government support for enrolment in the health insurance scheme.

105. The Health Insurance Board (HIB) has made significant improvements in the past couple of years to settle claims since the insurance scheme started. However, there are still challenges in terms of timely claims management. Currently the benefits package and its pricing are being updated. This needs to be integrated into the claims/insurance management system. Similarly, for HIB to make payments to the hospital, the hospitals need to be renewed and meet regulatory requirements. However, as hospitals take considerable length of time for renewals, people have faced difficulty in making timely claims. Currently there are about 25,000 claims per day and a staff can process on an average 300 to 500 claims. As the insurance schemes widens, there will be more claims, thus the need for institutionalizing a digitized system. Besides, enabling policy environment and capacity building support are also required by the HIB to effectively carry out their responsibilities. Yet, despite these hurdles, there are positive impacts made by the HIB. The HIB has 7 target groups from which disaggregated data is collected and reports are published. These target groups, among others, include Elderly, People with HIV, People with TB, Women Social Workers and People with Disabilities. A separate Toll Free Number has been provided for grievances where almost all grievances are received. Some grievances are also received through "Hello Sarkar" and Emails. Barring a few grievances requiring policy decisions, HIB resolves almost all of the grievances. HIB has 10 operational guidelines and additional 15 guidelines are being developed this fiscal year.[26]

[25] Inferred from consultations with stakeholders at the sub-national and local levels and from review of Assessment of Social Health Insurance Scheme in Selected Districts of Nepal, Government of Nepal, Nepal Health Research Council Kathmandu, Nepal, 2018

[26] Inferred from interaction with Executive Director of HIB

Grievances Redress Mechanism

106. The MoHP established a well-structured GRM for the COVID-19 Emergency Response Health Systems Preparedness Project. Grievance redressal services were offered at no cost to communities and without retribution. It did not impede access to judicial and administrative remedies. The GRM envisaged to:

- Provide affected people with avenues for making complaints or resolving any dispute that may arise;
- Ensure that appropriate and mutually acceptable redress actions are identified and implemented to the satisfaction of complainants;
- Avoid the need to resort to judicial proceedings (at least at first); and
- Adopt culturally appropriate and accessible means by which IPs can lodge complaints for redress, considering their customary dispute settlement mechanisms.

107. The GRM was overseen by a two tiered structure. The first tier includes Grievance Handling Unit under the Director General (DG), DoHS while Provincial Health Directorates are considered the second tier. The Deputy Director General has been designated the focal person of DoHS. All the Provincial Health Directorates were required to act as the Grievance Handling and Redressal Centers. DoHS assigned a focal person/position at each grievance handling and redressal centres. The steps to be followed by the GRM are presented in the table below.

The GRM included the following steps:

- Receive and register all grievance made either orally or in writing or through telephone hotlines/toll free numbers, SMS, project staffs involved in handling grievances or other staffs that have direct contact with affected communities and if necessary, anonymously.
  - Collecting grievances and acknowledging it within 24 hours.
  - the grievance will be tracked throughout the processing cycle to reflect their status and other important details.
- Review and investigate grievances
  - Complaints categorised depending on the nature and complexity.
  - Focal person to validate the complaint and arrange for investigation by concerned units or departments within 2 days.
- Develop resolution options commensurate with the nature of grievances within 7 days.
- As a respond to grievances, focal person communicates to the complainant of findings and the outcome within 24 hours. If the grievance remains open, complainant will be given opportunity to appeal to the MoHP.

108. The existing GRM are also being used for addressing GBV-related issues. GBV cases are being handled by the Nursing Division. The project had an additional procedure of handling the GBV-related issues that was be put in place for confidential reporting with safe and ethical documentation of GBV issues. Grievances related to highly sensitive cases or as per the wish of the complainant were to be filed anonymously, which is essential for capturing any GBV (gender-based violence) and SEA (sexual exploitation and abuse) related grievances that may arise. Further, the GRM contains a robust mechanism to immediately notify both the MoHP and the World Bank of any GBV complaints, with the consent of the survivor.

109. With the emergence of the COVID 19 pandemic, telephone tool free hot lines have been used to register grievances. The MoHP, in collaboration with development partners, set-up two cal

centers (1115 & 1113)[27] in 2020 to respond to COVID 19 related queries and referrals as well as grievances. A one day orientation program on GBV and SEA/SH was organized on October 6, 2021 with the support from WHO for 46 call center operators working at Epidemiology and Disease Control Division (EDCD). Further, the process and mechanisms for case recording, reporting and referral were discussed alongside overall error management of both incoming and outgoing calls. Information on cases physical and gender-based violence are recorded and forwarded to supervisor, and also the caller are referred to Women Police Cell and suggested to seek for help. In 2021, 4 such cases were referred to the Women Police Cell.[28]

110. Owing to a lack of resources and capacity, the GRM mechanism is yet to be fully functional and systematically managed at the provincial and local levels. The existing GRM also needs to be upgraded with e-mechanism for confidential reporting.

GRM in healthcare facilities

111. The Guideline for the Establishment, Operation and Up-gradation of Health Facilities, 20i4 requires HFs to: i) set-up a room where service seekers can register their grievances related to the services provided; and iii) establish an adequate GRM to address the grievances. A complaint box is also available in healthcare facilities for service users to formally file their grievances/suggestions to the relevant authorities. However, it was reported by stakeholders consulted that service seekers seldom used this mechanism for registering their grievances. In general, complaints were made with respect to a problem perceived as severe. Usually, those who were educated and financially more secure complained; but the general public, especially the poor and vulnerable groups, did not tend to so. Service users placed complaints in the suggestion boxes very rarely because they did not know about their existence, did not know how to make complaints, or thought it would take a long time to get a response.

112. The most common complaints made by service users were related to medicines, service providers, and health facility opening hours indicating individual-level complaints are related to broader system level issues. Broadly, the complaints fell into four categories: i) environment/equipment; ii) accessibility/availability; iii) empathy; and iv) care/safety Overall, a proper system for recording complaints and analyzing them at either the provincial/local government or health facility levels has not been fully institutionalized.

113. Different factors determine the reasons for choosing a particular route for complaining. Mostly informal approaches are used. This is mainly due to a lack of an established culture of using formal written channels and the suggestion boxes. Thus, complaints are, usually, directly conveyed to the service providers. Others who did not have access to direct communication with service providers, make complaints indirectly via HFOMCs, FCHVs, or by sharing with their community leaders. Approachability and accessibility were major factors for determining the channels applied for putting forth the grievances. The possible explanations for not making complaints are presented in the box below.

- **The lack of awareness** by service users about the existing complaint mechanisms or how to use them, are major hindrances.
- **Lack of information** about health facilities and services is one of the key reasons why service

[27] 1113, with the support of WB, was initially set-up in the Health Emergency Operation Center and is now located in Bir Hospital and 1115 was supported by WHO,
[28] Proposal Presentation on Callers Satisfaction Survey with COVID 19 Call Center Services, 17 January, 2021, Health Emergency and Disaster Management Unit, MoHP

users, especially Dalit, uneducated, and poor, did not make complaints.

- **Power differentials between service users and service providers** were a common cause for not complaining. The general public looked up to service providers and perceived them as high salary, respected people in society.
- Service users do not want to make health service providers unhappy by making complaints due **to limited opportunity to opt for alternative service providers**.
- **There is a lack of established culture of questioning providers.** There is low culture developed among service users to ask 'why' when things were perceived as inadequate. There is an attitude of accepting 'business as usual as being okay' among service users.
- In general, there is a **perceived lack of responsiveness to grievance**s made by service seekers. The service users also do not complain because they had a feeling that there would be no response from service providers to the complaints made.

(Source: Why service users do not complain or have 'voice': a mixed-methods study from Nepal's rural primary health care system; Gagan Gurung1*, Sarah Derrett2, Robin Gauld3 and Philip C. Hill)

Community Consultation and Information Disclosure

114. The "Social Accountability Federal Guidance for the Health Sector, 2021" was published and approved by the ministerial decision of the MoHP with the objectives to ensure access and participation of citizens in basic and emergency health services, providing notice and information to citizens about health service delivery and health related programs, to maintain the quality of the government's performance and provide opportunities for social auditing, increasing citizen awareness for reforms, creating positive pressure from citizens, making the citizen support system active, making health institutions accountable for citizen friendly health services, and making health services inclusive. Human resources on social accountability has been developed through the provisions of Training for Trainers (ToT) and orientations on the Guideline has been provided to health coordinators and sub-health coordinators in four provinces (Province 1, Madesh Province, Karmali Province and Soodorpaschim Province). The Curative Services Division, under the approved program for the fiscal year 2022/23, has conducted the orientation program on "Social Accountability Federal Guidance for the Health Sector, 2021" to facilitate completion of the social audit program in the 12 local levels of the four provinces as a pilot testing program. The final social audit reports of 11 out of 12 local levels have been received by this division.[29]

115. Community consultation, proper information disclosure and citizen engagement help create citizens' ownership and promote good governance in health facility management and service delivery. The Program will devise a Stakeholder Engagement Plan (SEP) which will be guided by the WHO Risks Communication and Community Engagement (RCCE) Protocol; the World Bank's ESS 10; Technical note on Public Consultations; and Nepal's National Health Communication Policy 2012. The SEP will adopt specific and targeted approaches to ensure that the vulnerable and marginalized groups have meaningful participation in the decision-making and implementation of the Program activities. The SEP will be informed by identification of vulnerable or disadvantaged individuals (such as indigenous people, ultra-poor and people with disability) along with their limitations in participating in the Program's consultation process (such as language differences, cultural barriers, lack of safe transportation to events, accessibility of venues, disability, lack of understanding of a consultation process). Further, there is scope for scaling-up of the social audit program of MoHP in Province 1 and Gandaki province.

[29] Report on Social Auditing Program, 2078/079, Curative Division, DoHS

3 ASSESSMENT OF CAPACITY AND PERFORMANCE OF IMPLEMENTING AGENCIES

116. Drawing on the presentation in Section 2, this Section summarizes the assessment of the capacity of the MoHP, DoHS as well as Provincial/Local Governments and healthcare facilities to effectively manage the E&S risk for the implementation of the NQHSP within the existing system as defined in various laws, regulations, procedures and implementing guidelines.

3.01 Adequacy of the Environmental and Social Management Framework for Addressing Environmental & Social Risks

117. In recent times, environmental and social concerns have been taken into account and embedded in the planning and design stage of health sector programs. In the course of the Nepal COVID-19 Emergency Response and Health Systems Preparedness Project, a comprehensive framework was developed by the MoHP in August 2020 for more enhanced safeguards compliance. Furthermore, the GoN has introduced new legislations, standards, strategies, and programs for more effective management of E&S concerns such as healthcare waste management, occupational health safety and targeted programs for enhancing the access of poor and vulnerable groups to health services. However, the implementation of these existing legal and regulatory provisions, at the provincial and local levels, faces challenge due to regulatory deficiencies, shortage of human resource, inadequate institutional capacity and inadequate budget allocation.

118. The subsequent frameworks, though designed to address project specific issues, have taken into consideration the overall E&S risks in the health sector. These frameworks can be revised/updated and contextualized, made more comprehensive and adequately contextualized to be applicable for all sectoral projects/programs in alignment with the federal structure of governance. The ESMF, as it stands now, does not envisage any role for provincial governments and the local governments. The commitment towards better E&S risk management planning and implementation can be further reinforced by the appointment of a dedicated safeguards focal person in the MoHP.

119. Stakeholder consultation is one of the most important elements of the environmental and social management process. This is covered and well-articulated in MoHP's GESI Strategy. Furthermore, MoHP's project specific ESMFs, have applied a Stakeholder Engagement Plan for all project financed activities throughout the project cycle. During the COVID-19 pandemic, the Public Information Coordination Unit under the Health Coordination Division of the MoHP, which is led by a joint secretary and the spokesperson of the ministry, was responsible for the dissemination of health related information. The commitment of the MoHP towards better safeguards planning and implementation was further reinforced by the appointment of a dedicated safeguards focal person in the MoHP.

120. The ESMF recognizes that vulnerable groups particularly women and Indigenous People need to be consulted. Special attention was also accorded towards minimizing their limitations in accessing information, accessing medical services, participating in project consultations, and articulating their concerns and priorities. This, among others, included identification of vulnerable or disadvantaged individuals such as indigenous peoples, people with disabilities and the limitations they may have in participating and/or in understanding the project information or participating in the consultation process. Various engagement methods such as briefings by health experts, site visits, focus group discussions, community fora, and radio, television, and print broadcasting were applied.

121. The IAs' capacity, interagency coordination, and the likelihood that objectives of applicable E&S systems will be met is presented below (Table 7).

Table 7: Implementing Agencies Capacity, Coordination & Likelihood Meeting Environmental & Social Objectives		
Adequacy of Capacity (Policies, Human Resource, Budget &Training)	**Interagency Coordination**	**Likelihood that objectives of applicable environmental &social systems will be met**
Implementing Agency: Ministry of Health and Population (MoHP)		
Policies and plans and trained human resource and budget are in place to carry out the defined responsibilities under the applicable system particularly in terms of policy guidance and exercising oversight.	Is ideally placed in terms of mandates and human resource to ensure interagency coordination but is hampered by the lack of clearly defined roles, responsibilities, and accountability of all the three tiers of governments including sectoral entities under their jurisdiction. This is urgently needed to do away with the confusion and anomalies in the roles, responsibilities and accountability.	The likelihood that objectives of applicable Environmental & Social(E&S) systems in MoHP will be met is high.
Implementing Agency: Department of Health Services (DoHS)		
Policies and plans and trained human resource and budget are in place to carry out the defined responsibilities under the applicable system particularly in terms of policy implementation, monitoring, capacity development of human resource under its jurisdiction as well as providing guidelines and orientation on E&S safeguards and operation of Health Management Information System (HMIS) to implementing agencies (IAs) at the provincial and local levels.	Is ideally placed in terms mandates and human resource to ensure inter-agency coordination but is hampered the lack of clearly defined roles, human resource, responsibilities and accountability of all the three tiers of governments including sectoral entities under their jurisdiction. This is urgently needed to do away with the confusion and anomalies in the roles, responsibilities and accountability.	The likelihood that objectives of applicable E&S systems in DoHS will be met is high.
Implementing Agency: Provincial Government		
Lacks policies and act and adequate human resource and budget to carry out the defined responsibilities under the applicable system particularly in terms of providing policy guidance and exercising oversight.	HCF operational level coordination is regular as federal grants require periodical reporting ,coordination with federal entities is regular. Policy level coordination is nominal. Similarly except for the responsibility of fulfilling some specific functions in the health sector that require some coordination with LGs, provincial governments' cooperation with LGs	The likelihood that objectives of applicable E&S systems in provincial government will be met is medium.

Table 7: Implementing Agencies Capacity, Coordination & Likelihood Meeting Environmental & Social Objectives		
Adequacy of Capacity (Policies, Human Resource, Budget &Training)	**Interagency Coordination**	**Likelihood that objectives of applicable environmental &social systems will be met**
	is nominal particularly in relation to application and monitoring of E&S systems. Informal coordination with LGs, depending on individuals, is mostly prevalent. The need for a formal coordination mechanism has been emphasized.	
Implementing Agency: Local Governments		
▪ Lack of policies, guidelines and adequate human resource and budget to carry out the defined responsibilities under the applicable system particularly in terms of implementation and monitoring of safeguard measures in healthcare facilities. ▪ LGs have the technical human resource for identifying and managing E&S issues, but they are overburdened with multi-sectoral responsibilities and can only afford limited time towards environmental and social safeguards management in the health sector. ▪ Has not institutionalized supervision and inspection of healthcare including application of safeguard measures. ▪ Has not designated a safeguard focal person.	▪ Barring implementations of programs using federal grants that require periodical reporting, coordination with federal entities is nominal. ▪ Interaction and coordination with provincial government & its entities is nominal. ▪ Informal coordination with provincial governments, depending on individuals, is mostly prevalent. The need for a formal coordination mechanism has been emphasized.	The likelihood that objectives of applicable E&S systems in LGs will be met is low.
Implementing Agency: Healthcare Facilities		
▪ Are mostly unaware about safeguards requirements devised by MoHP. ▪ Complies with federal legal provisions stipulated in Environmental Protection Acts and Rules	Coordination and interaction with federal, provincial and LGs are regular depending upon the jurisdiction they are under.	The likelihood that objectives of applicable E&S systems in HCFswill be met is medium.

Table 7: Implementing Agencies Capacity, Coordination & Likelihood Meeting Environmental & Social Objectives		
Adequacy of Capacity (Policies, Human Resource, Budget &Training)	**Interagency Coordination**	**Likelihood that objectives of applicable environmental &social systems will be met**
▪ Have formed Grievances Redress Committees or appointed focal person for dealing with grievances which are filed through complaint boxes or reported verbally to service providers or HFMC members.		

4 ASSESSMENT OF BORROWER SYSTEMS RELATIVE TO THE PROGRAM PRINCIPLES

122. No significant negative impacts on the environment or society are envisaged from NQHSP activities. These are minimal in scale, with most adverse impacts limited to being site-specific and temporary. The program's positive social impact outweighs the adverse impacts. The applicability of core environmental and social principles to NQHSP by sub results is presented in below (Table 8).

Table 8: Applicability of Core Environmental and Social Principles to Nepal Quality Health Systems Program by Sub Results (SR)

Core Principle (CP) 1: Environment	CP2: Natural Habitats	CP3:Worker Health and Safety	CP4: Land Acquisition	CP5: Vulnerable groups	CP6: SocialConflict
Sub Result (SR) 1: Minimum service standards: Expedite the reforms to improve health facility readiness for quality healthcare at all public sector health facilities.					
Not applicable as only minor physical works supported by the Program under SR1.	**Not applicable** as only minor physical works supported by the Program under SR1. Activities under SR 1 will not change the existing environmental and social systems assessment processes that assess impacts on natural habitats.	**Applicable** as minimum service standards has provisions related to health workers occupational safety.	**Not applicable** as only minor physical works supported byt he Program under SR 1.	**Applicable** The sub-results area on health data systems, strengthened local level planning and emergency health preparedness will include gender and inclusion considerations, for example: disaggregation of data; addressing the needs of women, poor and vulnerable populations in planning &programming, and their access to services during emergencies.	**Applicable**. Addressing needs of women, poor & vulnerable groups will minimize social conflict.
SRI 2: Data systems: Build on the momentum of health data systems strengthening, mainly with regards to digitalizing health data to increase data quality and use, enhance efficiency of health systems, and improve quality of healthcare.					
Applicable. Improvement in digital database for MSS related to HCWM & OHS will contribute	**Not applicable** as only minor physical works supported by the Program under SR 2.	**Applicable** as improvement in n digital database for MSS related	**Not applicable** as only minor physical works	**Applicable.** Improvement in readiness and service provision at the public	**Not applicable**

Table 8: Applicability of Core Environmental and Social Principles to Nepal Quality Health Systems Program by Sub Results (SR)					
Core Principle (CP) 1: Environment	**CP2: Natural Habitats**	**CP3:Worker Health and Safety**	**CP4: Land Acquisition**	**CP5: Vulnerable groups**	**CP6: SocialConflict**
towards better HCWM and OHS in HCFs.		to OHS will contribute towards better OHS in HCFs.	supported by the Program under SR 2.	hospitals and primary level facilities as per MSS will benefit poor and marginalized communities & groups as they don't have other options for accessing health services	
SR 3:Medical equipment management: Introduce and scale-up an end-to-end digital system, processes and capacities to manage essential medical equipment not just to maximize their life and usage, but also to enhance the efficiency and effectiveness of healthcare.					
Applicable The proposed Program will contribute to the GRID agenda in Nepal in the procurement and upkeep of medical equipment Improvement in bio-medical technical capacity to support hospitals with repair and maintenance will reduce medical equipment waste	**Not Applicable**	**Not Applicable**	**Not applicable**.	**Not Applicable**.	**Not Applicable**
SR 4: National health insurance: Increased and sustained coverage of health insurance particularly among poor and vulnerable population, while pursuing institutional and digital reforms to strengthen the insurance system.					
Not applicable	**Not applicable** .	**Not applicable**	**Not applicable**	**Applicable.** Improvement in access to quality health service of poor and vulnerable group due to Increased coverage in the national health insurance	**Not Applicable**

Table 8: Applicability of Core Environmental and Social Principles to Nepal Quality Health Systems Program by Sub Results (SR)					
Core Principle (CP) 1: Environment	**CP2: Natural Habitats**	**CP3:Worker Health and Safety**	**CP4: Land Acquisition**	**CP5: Vulnerable groups**	**CP6: SocialConflict**
				program.	
SR5: Local capacity for health planning, budgeting, execution & monitoring: build institutional capacity and leadership for health planning, budgeting, execution and monitoring using data and evidence.					
Applicable.	**Not Applicable**	**Applicable** as health planning will give more emphasis to OHS	**Not applicable**	**Applicable**. More coherent, objective and evidence-based allocations for public health activities and basic healthcare delivery customized to local circumstances and needs Gaps identified through MSS assessments will be addressed to improve quality of healthcare as well as to mobilize resources for deploying RRTs and EMDTs in case of health emergency events. This will not only increase the efficiency of the local health system but is also expected to enhance equity through more nuanced targeting of poor and vulnerable and	**Not applicable**

Table 8: Applicability of Core Environmental and Social Principles to Nepal Quality Health Systems Program by Sub Results (SR)					
Core Principle (CP) 1: Environment	**CP2: Natural Habitats**	**CP3:Worker Health and Safety**	**CP4: Land Acquisition**	**CP5: Vulnerable groups**	**CP6: SocialConflict**
				out of reach populations.	
SR 6: Preparedness, planning and surveillance: strengthen health emergency preparedness, planning and surveillance at provincial and local levels.					
Not applicable	**Not applicable**	**Not applicable**	**Not applicable**	**Applicable** as relevant equity indicators will be incorporated in the HMIS to support LGs improving equity.	**Applicable** as improving equity will mitigate social conflict.
SR7:Rapid response capacity: Systematic formation, capacity building, equipping and deployment of RRTs and EMDTs as per the new RRT and EMDT guidelines at provincial and local levels					
Applicable as systematic formation, capacity building, equipping and deployment of RRTs and EMDTs as per the new RRT and EMDT guidelines at provincial and local levels will result in effective and sustainable structures and mechanisms for preparedness and response from the bottom of the pyramid	**Not Applicable** a	**Not Applicable**	**Not applicable**	**Applicable** as access of poor and vulnerable groups to RRTs and EMDT will improve	**Not Applicable**

Based on the assessment and stakeholder consultations, the ESSA determined that the following three of the six Core Principles apply to the Program:

Core Principle # 1: Promote environmental and social sustainability in the Program design; avoid, minimize, or mitigate adverse impacts, and promote informed decision making relating to the Program's environmental and social impacts.

123. The capacity to manage E&S risks exits but needs to be strengthened in terms of human resources and budget. The sector has developed set of guidelines and good practices but at present, there is no sector wide framework for screening and identifying any potential environmental and social issues before undertaking any works. There is no dedicated capacity to look into E&S risks particularly with regard to HCWM. The Program design promotes environmental and social sustainability in several ways. This is evident in terms of the following results that the Program is

expected to generate. For instance, improvement in digital database for MSS related to healthcare waste management (HCWM) & occupational health safety (OHS) will contribute towards better design and planning of HCWM and OHS in healthcare facilities (HCFs). The proposed Program will contribute to the GRID agenda in Nepal in the procurement and upkeep of medical equipment. Improvement in bio-medical technical capacity to support hospitals with repair and maintenance will reduce medical equipment waste. Systematic formation, capacity building, equipping and deployment of rapid response teams (RRTs) and emergency medical deployment teams (EMDTs), as per the new RRT and EMDT guidelines at provincial and local levels, will result in effective and sustainable structures and mechanisms for preparedness and response from the bottom of the pyramid.

124. Likewise, the Program will contribute towards promoting sustainable social benefits in several ways. For instance, the improvement in readiness and service provision at the public hospitals and primary level facilities, as per MSS, will benefit poor and marginalized communities as they don't have other options for accessing health services. Poor and vulnerable groups' access to quality health will significantly improve due to increased coverage of the Program's support to increased and sustained coverage of health insurance program particularly among poor and vulnerable populations. There will be more coherent, objective and evidence-based allocations for public health activities and basic healthcare delivery customized to local circumstances and needs. Gaps identified through MSS assessments will be addressed to improve quality of healthcare as well as to mobilize resources for deploying RRTs and EMDTs in case of health emergency events. This will not only increase the efficiency of the local health system but is also expected to enhance equity through more nuanced targeting of poor and vulnerable and out of reach communities. Furthermore, relevant equity indicators will be incorporated in the health management information system (HMIS) to support local governments (LGs) improving equity. The Program's sub-results area on health data systems, strengthened local level planning and emergency health preparedness will include gender and inclusion considerations, for example: disaggregation of data; addressing the needs of women, poor and vulnerable.

Core Principle # 3: Protect public and worker safety against the potential risks associated with: (i) construction and/or operations of facilities or other operational practices under the Program; (ii) exposure to toxic chemicals, hazardous wastes, and other dangerous materials under the Program; and, (iii) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards.

125. The National regulatory and policy frameworks provisions for labor work safety but is not adequate (no separate legislation on OHS) on addressing the issues related to the OHS. Although the Program will not support any major civil works, there are issues related to infection control and good operating practices by healthcare workers and other workers dealing with chemicals, medical equipment, and risks from infectious diseases. The provisions in Core Principle 3 are considered as part of the occupational health and safety issues related to chemicals usage, medical equipment and handling infectious waste and medical waste. The regulatory and policy frameworks for E&S safeguards, at the federal level are robust for avoiding, minimizing, or mitigating adverse E&S impacts and promoting informed decision-making at the federal level. However, challenges in implementation and monitoring compliance of E&S safeguard measures persist due to shortcomings in institutional capacities and adequacy of dedicated human resources and budget, particularly at the sub-national level.

126. The Environmental and Social Management Frameworks (ESMF), applied by the MoHP in earlier projects, need to be updated, contextualized, and uniformly applied across all sectoral projects/programs to address the E&S risk of the entire health sector. This updated ESMF needs to

incorporate relevant provisions in GoN's legislation, standards, and programs for more effective management of E&S concerns such as HCWM, OHS, and targeted approaches/frameworks for enhancing the access of poor and vulnerable groups to health services and clear institutional roles and responsibilities.

Core Principle # 5: Give due consideration to the cultural appropriateness of, and equitable access to Program benefits, giving special attention to the rights and interests of the Indigenous Peoples and to the needs or concerns of vulnerable groups.

127. The constitution of Nepal 2015 has declared all citizens as equal and provided a mandate for GESI to bring women, persons with disability, marginalized, vulnerable and excluded communities into the mainstream of development. Nepal has also shown legal commitment to GESI by ratifying international conventions, including Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), and the International Covenant on Civil and Political Rights (ICCPR), while also voting in favor of the UN Declaration on the Rights of Indigenous Peoples (UNDRIP).

128. In recent times, political commitment towards gender equality and social inclusion (GESI) has led to integration of GESI into the GoN systems. This is evident in terms of high priority accorded to GESI integration in GoN's policy and regulatory regimes. Furthermore, MoHP GESI Strategy, 2018 is focused on mainstreaming GESI in the Health Sector policies, strategies, system, plans, programs, budget and monitoring and evaluation of the federal, provincial, and local governments. It envisages promoting equitable access of health services by increasing targeted communities' access to and utilization of basic health services. The need now is to ensure the effective roll out and implementation of the Strategy at all levels of the federal structure for delivery of GESI responsive health services. The MoHP has formulated a new GESI policy which is in the process of final approval of the cabinet.

129. Special legal/regulatory provisions are in place for safeguarding the interest/concerns of IPs and vulnerable people, which is amply reflected in the ESMFs applied by the MoHP in earlier projects particularly in the recent COVID-19 Emergency Response and Health Systems Preparedness Project. An Indigenous People Management Framework (IPMF) has been inbuilt in this framework to i) ensure inclusion of targeted communities in the consultation process of the Program; ii) avoid, minimize, and mitigate any potential adverse impacts on indigenous and vulnerable communities; and iii) ensure vulnerable peoples' participation in the process of planning, implementation, and monitoring of the sub-program facilities. There is a need to give continuity to the application of this framework during the implementation of this Project.

Gaps and Challenges

130. The implementation of policies and regulatory regimes faces major challenges across the sector at the provincial/local level due to the following:

- The significance of E&S risk management in sub-national governments and health facilities is understood but the priority accorded to this aspect in terms of commensurate allocation of budget and dedicated human resource is low.
- Regulatory and policy frameworks for E&S risk management have not yet been adequately applied across the health sector.
- The institutional arrangement for implementation, management and compliance monitoring is grossly inadequate at the provincial and local levels;
- Weak capacity for effective implementation and monitoring of E&S safeguard requirements.
- Inadequate measures for ensuring OHS in health facilities.

- Marginalized and vulnerable groups still face the risk of being excluded from health services due to social, economic, cultural and geographical barriers. Ensuring continued access of women, men, girls and boys from remote locations, extreme poverty groups and with disability to non-interrupted quality health services is challenging.
- Ineffective GRM in healthcare facilities;
- Managing wastes generated from healthcare facilities, including e-waste, has emerged as one of the serious health issues.
- Disposal of untreated liquid waste in the public sewage system.
- Maintenance and operation of equipment related to disinfections of healthcare waste.

Opportunities

131. There exist ample opportunities for the NQHSP to support: i) the development, roll out and implementation of environmental and social risk management policies, rules and procedures at the provincial/local levels; ii) further strengthen the system for implementation, management and compliance of E&S risk management ; iii) capacity development of human resource in key sector organizations at the provincial/local level for effective implementations and monitoring of E&S safeguard measure; iv) enhancing transparency in vertical and horizontal flow of safeguard related information across the three tiers of governments and importantly to the target groups; v) institutionalizing GESI responsive structures and systems in the health sector across the federal structure in alignment with provisions in MoHP GESI Strategy, 2021; vi) Institutionalization of an effective GRM in healthcare facilities; and vii) enhancing collaboration and coordination among the three levels of government on E&S risk management (implementation and compliance).

5 ACTION PLAN TO ENHANCE ENVIRONMENT AND SOCIAL MANAGEMENT CAPACITY/PERFORMANCE

Key Gaps and Challenges Requiring Immediate Actions

132. The ESSA has identified key gaps/challenges requiring immediate actions which have been segregated in terms of: i) Institutional arrangement; ii) Capacity to manage and implement E&S safeguard measures; and iii) Monitoring compliance of implementing agencies across the three levels of the federal structure. The Program will require increased coordination among various departments and Ministries and with provincial and local government and stakeholders on environmental and social aspects to support implementation.

C. Institutional arrangement

- The provincial and local governments lack adequate policies/safeguards and systems for the implementation of environmental or social risks management applicable to the program. A dedicated unit or focal person has not been designated at the provincial and local level. This includes lack of mandate and coordination to roll out national health insurance program, integrated surveillance, disaster, and emergency response plans, coordination on healthcare GESI strategy, and management of healthcare waste.
- Lack of an E&S framework for the health sector that can be uniformly applied across all sectoral project/programs.
- Lack of effective mechanism for coordination between federal, provincial, and local government line agencies for managing the implementation E&S measures.
- Lack of GESI responsive structure and adequate resources for implementation in IAs at the provincial and local level. Though few provinces have taken initiatives to integrate GESI strategy, approval from the government would enable in implementation of GESI strategy at the local level.

D. Capacity to manage and implement E & S risk management m**easures**

- The capacity, at the provincial and local governments and in healthcare facilities, for managing environmental and social risks are inadequate and need strengthening in terms of knowledge/skill and financial resources. There is a shortage of dedicated human resource for management and implementation of safeguard measures and GESI strategy.
- Managing wastes generated from healthcare facilities, including e-waste, has emerged as one of the serious health issues in Nepal. There is also the issue of capacity and resources gaps in managing OHS risk related to HCW handling.
- Maintenance and operation of equipment related to disinfection and treatment of healthcare waste is also challenging due to shortage of skilled technical resource and lack of budget.
- Inadequate and/or ineffective identification and outreach of ultra poor families has resulted in their low coverage by the health insurance program and challenges in rapid response or emergency response.
- Lack of enabling and accessible quality services
- Accountable services that promote service seeking behavior of people,

C. Monitoring Compliance

- Environment and social performance/compliance monitoring and verification audit procedures for meeting minimum conditions related to environmental and social safeguards at all levels of governments are inadequate.
- The federal and sub-national governments lack adequate budget for environment & social management including for monitoring safeguards measures.
- The lack of integrated HMIS and EMR results in proper monitoring mechanism and GESI strategy.

The proposed action and implementation plan to enhance E&S management performance and capacity are presented below (**Error! Reference source not found.**).

Table 9: Action and implementation plan to enhance E&S management performance and capacity

Action Description	Source	DLI#	Responsibility	Timing	Completion Measurement
Three district level hospitals, each in province 1 and Gandaki province equipped with i) functional technology (autoclave, needle cutter and other present and in working condition etc.) ii) trained and dedicated human resource to operate autoclave and other equipment iii) adequate budget for complete end disposal of health care waste management as per the National health care waste management, standards and operating procedures 2020 .	**DoHS/Provincial Health Directorate**	**No**	**Provincial Hospitals/Rural&Urban**	**2025**	**Guidelines for end disposal of healthcare waste present and activities carried out accordingly in selected hospitals**
MOHP's GESI Strategy to be rolled out at the Local Levels ensuring that i. GESI data is incorporated into the HMIS with GESI reporting, and iii. Mechanism for coordination with local authorities and committees to streamline GESI in access and healthcare service delivery.	**MOHP/ Local Levels**	**No**	**Local Levels/health facilities**	**2024 and continuous**	**Key functions of Local Levels under GESI strategy with HMIS integration and GESI mechanism carried out in Program areas**
Prepare and endorse Sector wide ESF (or guideline) for all the activities 9including civil works) executed by MoHP	**MOHP**	**No**		**2025**	**An endorsed ESF**
Outreach and enrollment ofultra poor households based on the defined GESI categories in the health insurance scheme	**Health Insurance Board (HIB)**	**DLI 2**	**HIB/ Local Levels**	**2025 and continuous**	**Achievement of DLI targets as defined under DLI matrix**

Health Emergency Preparedness and Response plans to include local authorities, committees, and community participation and healthcare waste management	**DOHS/EDCD**	**DLI 5**	**EDCD/Local levels**	**2025 and continuous**	**Achievement of DLI targets as described under DLI matrix**
Use of eGP system throughout the procurement cycle	**DOHS**	**No**	**DOHS**	**Continuous**	**At least 10% of annual procurement of DOHS to be tested to be channeled through e-GP system in entirety, by 2nd year. To be scaled up depending on the lessons.**
Implement internal control guidelines	**MOHP**	**No**	**MOHP and cost centers**	**Continuous**	**Provision of guidelines, trainings, conduct of audit action committees and resolution of audit queries**
Enhance the existing GRM mechanism to make it more integrated, systemic and digitized	MoHP/DoHS, Provincial Government, LGs & Healthcare Facilities	**No**	**MOHP and DOHS**	**Continuous**	GRM mechanism digitized & functional

APPENDICES

Appendix 1: Environmental and Social Management Principles and Attributes

Core Principle	Key Attributes
General Principle of Assessment and Management	
Environmental and social management procedures and processes are designed to (i) avoid, minimize or mitigate against adverse impacts; (ii) promote environmental and social sustainability in program design; and (iii) promote informed decision making relating to a program's environmental and social effects.	Whether for design of new programs or program activities, or for support to existing programs or activities, the Bank will confirm that, as relevant, program procedures: 1. are backed by an adequate legal framework and regulatory authority to guide environmental and social impact assessments *at the programmatic level.* 2. incorporate recognized elements of environmental and social assessment good practice, including: (i) early screening of potential effects; (ii)consideration of strategic, technical, and site alternatives (including the "no action" alternative);(iii)explicit assessment of potential induced, cumulative and trans-boundary impacts; (iv) identification of measures to mitigate adverse environmental or social impacts that cannot be otherwise avoided or minimized; (v) clear articulation of institutional responsibilities and resources to support implementation of plans; (vi) responsiveness and accountability through stakeholder consultation, timely dissemination of program information, and through responsive grievance redress measures.
Environmental Considerations (as relevant)	
Environmental management procedures and processes are designed to avoid, minimize and mitigate against adverse effects on natural habitats and physical cultural resources resulting from program activities or investments.	1. Program planning and implementation includes appropriate measures for early identification and screening of potentially important biodiversity and cultural resource areas. 2. Program avoids the significant conversion or destruction of natural habitats and where not technically feasible the program includes measures to mitigate or offset impacts or program activities. 3. Where appropriate, supports and promotes the pro-active protection, conservation, maintenance, and rehabilitation of natural habitats. 4. Program planning and implementation takes into account potential adverse effects on physical cultural property and, as warranted, includes adequate measures to avoid, minimize or mitigate such effects.
Environmental management procedures and processes are designed to protect public and worker safety against the potential risks associated with: (i) construction and/or operations of facilities or other operational practices developed or promoted	1. Promotes community, individual and worker safety through the safe design, construction, operation and maintenance of physical infrastructure, or in carrying out activities that may be dependent on such infrastructure with safety measures, inspections or remedial works incorporated as needed. 2. Promotes use of recognized good practice in the production, management, storage, transport, disposal of hazardous materials generated through program construction or operations and promote use of integrated pest management practices to manage or reduce pests or disease vectors and provides training for workers involved in the production,

Core Principle	Key Attributes
under the program; (ii) exposure to toxic chemicals, hazardous wastes and otherwise dangerous materials; (iii) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards.	procurement, storage, transport, use and disposal of hazardous chemicals in accordance with international guidelines and conventions. 3. Includes measures to avoid, minimize or mitigate community, individual and worker risks when program activities are located within areas prone to natural hazards such as floods, hurricanes, earthquakes, or other severe weather or climate events.
Social Considerations (as relevant)	
Due consideration is given to cultural appropriateness of, and equitable access to, program benefits, with special emphasis provided to rights and interests of indigenous peoples, as well as the needs or concerns of vulnerable groups.	1. Free, prior and informed consultations are undertaken if indigenous peoples are potentially affected (positively or negatively), to determine whether there is broad community support for program activities. Ensure that indigenous peoples can participate in devising opportunities to benefit from exploitation of customary resources or indigenous knowledge, the latter to include the consent of the indigenous peoples. 2. Program planning and implementation includes attention to groups vulnerable to hardship or disadvantage, including as relevant the poor, the disabled, women and children, the elderly, or marginalized ethnic groups. If necessary, special measures are taken to promote equitable access to program benefits.
Avoid creating or exacerbating social conflict, especially in fragile states, post-conflict areas, or areas subject to territorial disputes.	Include conflict risks in program assessment, and include consideration of distributional equity, cultural sensitivities, or other conflict risk factors in program design.

Appendix 2: Summary of Core Principles and Attributes

*Please note these guiding questions are paraphrased from the Core Principles, which can be found in full text in Tables 4.1a–4.1c of the Environmental and Social Effects Guidance Note.
Are there established Environmental and Social Management Procedures and processes to (i) avoid, minimize or mitigate against adverse impacts; (ii) promote environmental and social sustainability and (iii) promote informed decision making?
Is there an adequate legal framework and regulatory authority to guide environmental and social impact assessments at the programmatic level? Are recognized elements of environmental and social assessment good practice incorporate? Including: Early screening of potential effects? Consideration of strategic, technical, and site alternatives (including the "no action" alternative)? Explicit assessment of potential induced, cumulative and trans-boundary impacts? Identification of measures to mitigate adverse environmental or social impacts that cannot be otherwise avoided or minimized? Clear articulation of institutional responsibilities and resources to support implementation of plans? Responsiveness and accountability through stakeholder consultation, timely dissemination of program information, and through responsive grievance redress measures?

Environmental Considerations
Are adverse effects from program activities or investments on natural habitats and physical cultural resources avoided, minimized and mitigated?

Early identification and screening of potentially important biodiversity and cultural resource areas? Is significant conversion or destruction of natural habitats avoided? Or mitigation measures or offsets included when avoiding natural habitats is not technically feasible? Supports and promotes the pro-active protection, conservation, maintenance, and rehabilitation of natural habitats, where appropriate? Are potential adverse effects on physical cultural property accounted for and adequate measures to address such effects?

Are there adequate measures to protect community and worker health and safety against potential risks (i.e., construction, hazardous chemicals, etc.)?

Is there adequate community, individual and worker safety through the safe design, construction, operation and maintenance of physical infrastructure? Has good practice been used in the production, management, storage, transport, disposal of hazardous materials?

Are integrated pest management practices used to manage or reduce pests or disease vectors? Have workers been provided training for workers involved in the production, procurement, storage, transport, use and disposal of hazardous chemicals in accordance with international guidelines and conventions? Are adequate measures included to ensure risks are addressed when program activities are located within areas prone to natural hazards?

Social Considerations

Has cultural appropriateness and equitability or access for Indigenous Peoples and Vulnerable Groups been accounted for?

Has free, prior and informed consultations if indigenous peoples are potentially affected (positively or negatively) been conducted, to determine whether there is broad community support for program activities? Have indigenous peoples participated in devising opportunities to benefit from exploitation of customary resources or indigenous knowledge (the latter including the consent of the indigenous peoples)? Has attention been given to groups vulnerable to hardship or disadvantage,

including as relevant the poor, the disabled, women and children, the elderly, or marginalized ethnic groups? Have any special measures been taken to promote equitable access to program benefits? *Avoided Creating/Increasing Social Conflict?*

Appendix 3: List of Documents Reviewed

S.N.	Document Reviewed
01	Concept Note, Nepal Quality Health Systems Program-for-Results (P177389)
02	Environmental and Social Assessment Framework, Nepal COVID-19 Emergency Response and Health Systems Preparedness Project, MoHP, GoN
03	Annual Report 2077/78 (2021/22), Department of Health Services, MoHP, GoN
04	Review of the Scale-up, Functionality and Utilization, including Barriers to Access, of One Stop Crisis Management Centres, DoHS, 2020
05	Why Service Users Do Not Complain or Have 'Voice': a Mixed-methods Study from Nepal's Rural Primary Health Care System; Gagan Gurung1*, Sarah Derrett2, Robin Gauld3 and Philip C. Hil
06	Environment and Social Management Framework, Nepal COVID 19 Emergency Response and Health Systems Preparedness Project, August 2020, MoHP, GoN
07	Nepal Law Commission. The Constitution of Nepal, 2015.
08	Nepal Health Facility Survey, Final Report, MoHP, GoN
09	National Health Care Waste Management Standards and Operating Procedures, 2020, MoHP
10	Nepal Health Facility Infrastructure Development Standard, 2017, Ministry of Health, GoN
11	The Public Health Service Act, 2075 (2018), MoHP, GoN
12	National Health Policy, 2019, MoHP, GoN
13	The Right to Information Act, 2007
14	The Sexual Harassment at Workplace Prevention Act, 2015 (2071)
15	The Caste-based Discrimination and Untouchability Act, 2011
16	The Environment Protection Act, 2019
17	The Environmental Protection Rules, 2020
18	The National Environmental Policy, 2019
19	The Climate Change Policy, 2019
20	Nepal Health Insurance Act, 2017
21	Disaster Risk Reduction and Management Act 2015
22	The 15th Plan (FY2019/2020–2023/2024)
23	Land Acquisition Act (1977) and Land Acquisition, Resettlement and Rehabilitation Policy for Infrastructure Development Projects (2015)
24	Minimum Service Standards, Checklist to Identify Gaps in Quality Improvement in Primary Hospitals, MoHP, GoN, 2018
25	Drinking Water Regulation, 1998
26	Solid Waste Management Act, 2011
27	The National Building Code, (NBC) 105 (2020)
28	Standard Guidelines for Post-Disaster Reconstruction of Health Buildings: GoN, Ministry of MoHP, 2015
29	Forestry Policy (2015)
30	Local Government Operations Act, 2017
31	Solid Waste Management Act, 2011