



THE WORLD BANK

**NEPAL:
HEALTH SECTOR MANAGEMENT REFORM
PROGRAM FOR RESULTS**

ENVIRONMENT AND SOCIAL SYSTEMS ASSESSMENT (ESSA)

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ACRONYMS AND ABBREVIATIONS

DHIS	District Health Information System
DLIs	Disbursement-linked Indicators
DoHS	Department of Health Services
DHO	Department of Environment
DoE	District Health Office
DPHO	District Public Health Office
EPA	Environment Protection Act
ESSA	Environmental and Social System Assessment
HFOMC	Health Facility Operation and Management Committee
GESI	Gender Equality and Social Inclusion
KMC	Kathmandu Municipal Corporation
KVDA	Kathmandu Valley Development Authority
MoH	Ministry of Health
MoPE	Ministry of Population and Environment
MoUD	Ministry of Urban Development
MoFALD	Ministry of Federal Affairs and Local Development
MoWSS	Ministry of Water supply and Sanitation
NHRC	Nepal Health Research Council
NHSS	Nepal Health Sector Strategy
OOP	Out-of-pocket
PDO	Program Development Objective
Pfor	Program for Results
RHDs	Regional Health Directorates
SWMTSC	Solid Waste Management Technical Support Centre
SWOT	Strengths-Weaknesses-Opportunities-Threats approach
TWG	Technical Working Group
UHC	Universal Health Coverage
WASH	Water, Sanitation and Hygiene

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EXECUTIVE SUMMARY

The Program for Results (PforR) will support a subset of the Nepal Health Sector Strategy (NHSS 2015-2021) which outlines the Government of Nepal’s (GoN) program towards achieving its goal of Universal Health Coverage (UHC). The government’s reform program recognizes that improved health outcomes hinge on the ability of the Ministry of Health (MoH) to direct public resources to areas of need, and to react to and make evidence-based decisions. The PforR focuses on those outcomes/sub-outcomes of NHSS which aim to strengthen supply and demand side constraints of institutional performance to support more efficient use of resources for targeted and better service delivery over time.

In accordance with the World Bank’s Policy/Directive “Program-for-Results Financing”¹ the World Bank has conducted an Environmental and Social System Assessment (ESSA) of Nepal’s existing environmental and social management systems for the health sector. This includes assessment of the national legal, regulatory, and institutional framework used to address potential environmental and social impacts of the PforR operation. The overarching objective of the ESSA is to ensure that the risks and impacts of the Program activities are identified and mitigated, and to strengthen systems and build capacity to deliver the PforR in a sustainable manner.

The ESSA analyzed the environmental and social management system for the Program to determine applicability for the six Core Principles outlined in the Policy and ensure consistency with those that apply. The ESSA analysis was conducted using the Strengths-Weaknesses-Opportunities-and-Threats (SWOT) approach. The “weaknesses,” or gaps with the Policy, was considered on two levels: (i) the system as written in laws, regulation, procedures and applied in practice; and (ii) the capacity of Program institutions to effectively implement the system as demonstrated by performance thus far.

The ESSA analysis focused on the Bank financed PforR operation, which carves out specific boundaries of intervention within a wider GoN NHSS program. The PforR focuses on strengthening fiduciary systems and as such is not expected to have adverse environmental impacts. However, the Program provides an opportunity to strengthen and mainstream environmental and social issues within the systems strengthening objective of the PforR which will further support its overarching objective of improving health service delivery and accessibility. This opportunity is recognized by the GoN which has expressed interest and commitment to address the main environmental and social risks associated with the health sector service delivery in Nepal. 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: General Principle of Environmental and Social Management*** designed to promote environmental and social sustainability in Program design; avoid, minimize or mitigate against adverse impacts; and promote informed decision-making relating to a program’s environmental and social effects.

¹Catalogue Number OPCS5.04-POL.01

While considering the applicability of this Core Principle, the ESSA analysis found that it was relevant for the program in terms of improving infection control and waste management practices that have a direct impact on the objective of providing clean and safe health services. Discussions and consultations carried out as part of the ESSA analysis indicate a commitment, agreement and willingness by GoN, donor partners and non-governmental agencies to address issues that are compromising the efficiency of health services and posing a threat to the environment. The current practices at most healthcare facilities are deficient and inadequate, with poor infection control and occupational health and safety practices, unsatisfactory infectious waste management, including treatment and disposal of infectious wastes, which pose a risk of spread of infectious diseases. The health sector lacks a regulatory framework for infectious healthcare waste management and existing Guidelines are being implemented, but in a piecemeal manner due to insufficient resources. Pilot programs on good infection control practices, zero-waste initiatives and use of non-burn technologies have been successfully initiated and implemented, although not systematically replicated. The absence of a national strategy and coordinating institutional mechanism along with lack of clarity of roles and responsibilities of various agencies is an identified weakness.

- ***Core Principle 3: Public and Worker Safety*** to protect public and worker safety against the potential risks associated with exposure to toxic chemicals and hazardous wastes.

The ESSA analysis found that it was relevant for the program in terms of issues related to infection control and good operating practices by healthcare workers dealing with chemicals and risks from infectious diseases. However the provisions in this Core Principle are considered as part of the occupational health and safety issues related to chemicals usage and handling infectious waste as analysed under Core Principle 1.

- ***Core Principle 5: Indigenous Peoples and Vulnerable Groups***: Due consideration is given to cultural appropriateness of, and equitable access to, program benefits giving special attention to rights and interests of Indigenous Peoples and to the needs or concerns of vulnerable groups.

While considering the applicability of this Core Principle, the analysis found that this principle is relevant due to the need to ensure that vulnerable and marginalized groups, including indigenous people, are included in the planning process (especially needs prioritization), implementation and monitoring of program activities. The ESSA analysis of vulnerable groups focused on those defined in the 'Operational Guidelines for GESI Mainstreaming in the Health Sector', namely, groups who have been systematically excluded over a long time due to economic, caste/ethnic, disability and geographic reasons (e.g., women, Dalits, indigenous people, Madhesis, Muslims, people with disabilities', senior citizens, sexual and gender minorities, and people living in remote regions), poor, unreached groups, and underserved areas. Gender equality and social inclusion (GESI) are political priorities across GoN, and the MoH's GESI Strategy (2009) along with its Ten Point Health Policy and Programme (2006), which introduced Free Essential Health Care Services, has ushered in a stronger focus on reaching the poor and disadvantaged. The policy framework, a comprehensive institutional structure for GESI mainstreaming as well as the political commitments to gender and social inclusion have laid down the foundation to address gender and social exclusion issues in the health sector and integrating GESI into systems and services. However, weak institutional capacity, including insufficient allocation of financial and human resources to reach

vulnerable groups; incipient stages of GESI mainstreaming and centralized programming are some of the factors that impede effective health service delivery to vulnerable groups despite the fairly strong institutional and policy framework for mainstreaming GESI.

Based on the analysis, the ESSA identified the following main areas for action in order to ensure that the Program interventions are aligned with the Core Principles 1, 3, and 5 of the Policy for improved environmental and social due diligence.

Measures to Strengthen System Performance for Environmental and Social Management under Nepal Health Sector Management Reform PforR	
Objective	Measures
Systems for Environmental Management	<ul style="list-style-type: none"> • MoH to develop an Integrated Infection Control and HCWM Strategy by year 1 (including implementation plan and institutional responsibilities for coordination, implementation, monitoring and reporting); • Based on the strategy, MoH to liaise with MoPE for the review and revision of the existing HCWM Regulations which will (i) mandate institutional, implementation and enforcement responsibilities related to infection control and waste treatment and disposal; and (ii) annual budgetary allocations. This will be done in consultation with all key stakeholders in government, private and NGO sector and donor agencies; • MoH will facilitate MoPE and ensure that the Regulations are submitted for consideration by Cabinet by year 1.5 of the Program. • GoN to approve revised HCWM regulations by year 3 of the program.
Systems for Mainstreaming GESI	<ul style="list-style-type: none"> • MoH to expand the scope of GESI and improve the Operational Guidelines to include issues of disability, mental disabilities geriatrics and rehabilitation of GBV victims; and ensure inter-ministerial collaboration and coordination with civil societies and strengthen one-stop crisis centers.
Budgetary and Institutional Mechanism	<ul style="list-style-type: none"> • DLI Management and Coordination Unit at the MoH will be responsible for implementation ESSA action plan. This could be done in collaboration with Management Division of DoHS and Curative Division of MoH. • MoH to discuss with Ministry of Finance the requirement of a dedicated budget line with annual allocations within the MoH annual budget for HCWM by year 3. A flexible funding mechanism for DHOs and DPHOs to respond to local health needs and disparities and formalize criteria and implementation guidance to ensure that the needs and priorities of women and poor and excluded people identified through the DHIS and citizen engagement are addressed.
Technical Guidance and Implementation Capacity	<ul style="list-style-type: none"> • MoH to revise HCWM Guidelines to standardize procedures, processes and implementation arrangements for infection control and waste treatment and disposal; demarcate roles and responsibilities of primary agencies including enforcement, multi-agency coordination and

	<p>budgetary requirements (in parallel with revision of the Regulations) by year 2. The Guidelines should also include recommendations on waste treatment and disposal technologies, infrastructure and practices; use of personal protective equipment and occupational health and safety practices and supervision and reporting mechanisms.</p> <ul style="list-style-type: none"> ● MoH to develop and/or update existing guidelines and training modules and methodologies in line with the revised Regulations; Rolling out of training at central, regional, district and PHC levels by year 3. ● MoH to develop strategy for strengthening capacity of institutions and health facilities for mainstreaming GESI in planning, budgeting, implementation and monitoring. This will include improving coordination and collaboration between different levels with other government sectors, external development partners and civil society. ● MoH to provide support to gathering and analysis of evidence required for effective GESI planning, especially by utilizing information from the DHIS 2 and citizen engagement procedures. ● Continue consultations (with health staff and local community based organizations and NGOs working in the health sector, at divisional, central, district and regional levels) during the preparation of annual work plans and budgets to mainstream GESI activities. ● Continue trainings to strengthen the skills of staff and focal points for mainstreaming GESI in planning, budgeting, implementation and monitoring (especially in terms of identification of barriers faced by vulnerable groups in accessing health services; disaggregation of data and delivering services in a GESI sensitive manner).
<p>Systems for Information Disclosure and Stakeholder Consultation</p>	<ul style="list-style-type: none"> ● DLI 2, which focuses on establishing a Grievance Redressal Mechanism, will enable the provision of information on grievances received, addressed, and thereby provide full disclosure and transparency. ● DLI 11 will focus on developing and piloting citizen engagement mechanisms to gain feedback on availability of drugs and facility-level services. In accordance with this DLI, MoH will develop and operationalize pilot citizen feedback mechanisms and systems for public reporting for different geographical contexts and adapted accordingly. ● MoH will monitor and evaluate citizen engagement plans and improve district and central level responses. This will include a functional mechanism to ensure that findings from these citizen engagement mechanisms are used to improve accountability of service providers responsible for "supplying" services.

SECTION I: BACKGROUND

2.1 Country Profile

1. **Nepal has made significant progress in poverty reduction and human development, but these are now at risk.** With an annual per capita income of US\$730 (2014), about 25 percent of Nepal's population of 27.5 million lives on less than US\$1.25 per day and 82 percent lives in rural areas. The proportion of the population living on less than US\$1.25 per day has been halved from 53 percent in 2003/04. Life expectancy is 70 years (2014), up from 62 in 2000. Nepal has also achieved gender parity in education and sharp reductions in child and maternal mortality. Also, between 2006 and 2014, economic growth averaged 4.4 percent per year, and the budget has moved from a position of modest deficits to surpluses from FY2013 onward. Despite these positive trends, significant disparities persist, and the recent shocks, including the series of earthquakes since April 2015 and the disruption in trade between September 2015 and February 2016, have affected progress in poverty reduction. During FY 2015/16, growth plunged to a 14-year low of 0.77 percent, owing to the twin shocks of the earthquakes and prolonged disruption in supplies on account of the border crisis. Nepal ranks 130 of 168 on Transparency International's Corruption Perception Index for 2015, and poor transparency and accountability in the public sector remain a major concern.

2. **Nepal continues to pass through a complex and challenging political transition.** A new constitution was promulgated in September 2015, with several amendments introduced in January 2016, however there is a lack of consensus over issues such as the demarcation of provinces and the specifics of federalism. This has resulted in renewed political uncertainty and social tensions, which carry risks of policy paralysis, institutional erosion, and poor service delivery.

2.2 Health Sector in Nepal

3. **Over the past two decades, Nepal has successfully reduced infant and maternal deaths, and achieved the MDGs related to maternal and child mortality.** Between 1996 and 2006, the maternal mortality ratio decreased from 790 to 281 per 100,000 live births; and further reduced to an estimated 190 by 2013,² while under-five child mortality decreased from 141 deaths per 1,000 live births in 1990 to 36 in 2014.³ Further, Nepal has met the MDG target for measles immunization coverage with 92.6 percent of children vaccinated by their first birthday.⁴

4. **Public spending on health in Nepal is higher than the South Asian average.** Nepal spends about 2.3 percent of GDP of public funds on health compared to the South Asian average of 1.3 percent of GDP. With regard to the share of GoN spending of total health spending, Nepal performs better than the low-income countries average (43.3 percent versus 41.5 percent) and South Asian average share (43.3 percent versus 33 percent).⁵ Nepal also performs better in prioritizing health as defined by the share of health spending out of total government spending— 11.9 percent compared to approximately 4.5 percent for South Asia. The national policy commits Nepal to provide free basic health services for all. At present, government health services are provided through a network of about 4,100 health facilities and 31,500 staff across the country. Health posts and primary health

² WHO et al. 2014. *Trends in Maternal Mortality: 1990 to 2013*. Geneva.

³ UNICEF et al. 2015. *Levels and Trends in Child Mortality: Report 2015*. New York.

⁴ Nepal Central Bureau of Statistics and UNICEF, "Nepal Multiple Indicator Cluster Survey 2014 Key Findings."

⁵ Health Nutrition and Population Statistics database, 2013.

care centers offer basic services free-of-charge to the entire population and higher-level facilities offer services free-of-charge to the poor.

5. Gender equality and social inclusion (GESI) are political priorities for GoN, and the MoH's GESI Strategy (2009) along with its Ten Point Health Policy and Programme (2006), which introduced Free Essential Health Care Services, has ushered in a stronger focus on reaching the poor and disadvantaged. The Equity and Access Programme further signals commitment to community based, rights and empowerment approaches to address the multiple barriers that poor and disadvantaged communities face in accessing maternal and new born health care.

6. Despite these significant achievements at the national level, not all segments of society have benefitted equally from the improvements recorded. There is evidence of systemic exclusion of several population groups to access health services due to a variety of circumstances, including household income and education levels; location of residence; gender, social, ethnic, and religious identities; and linguistic background. Women living in urban areas are almost twice more likely to get skilled birth attendance compared to women living in rural areas; women with secondary education are almost twice more likely to access that service compared to women with no education; and women in the Terai are twice more likely to benefit than women in the mountain regions. With regard to socioeconomic groups, the percentage of deliveries assisted by skilled birth attendants is 10.7 percent for the poorest and 81.5 percent for the richest quintile. Further, while utilization of prenatal care is not significantly different between urban (95.1 percent) and rural (85.3 percent) areas, only 27.9 percent of births among the bottom 20 percent of the population took place at a health facility compared to 90.7 percent in the richest quintile.⁶ This is further compounded by the low quality of care at health facilities. Only 60 percent of basic emergency obstetric and neonatal care facilities provided round-the-clock functions expected of them.⁷

7. Weaknesses in health systems and public sector management inefficiencies contribute to the low quality of care and inequities in health outcomes. Various binding constraints contribute to weak public sector management in health. These include inadequate oversight by the MoH due to low capacity, weak information systems, poor accountability at most levels and inadequate and fragmented mechanisms for citizen engagement. Structural and institutional inefficiencies in planning, management, and delivery of the program contribute to the lack of timely availability of these free services and drugs, particularly to poor and difficult-to-reach population groups. Financial protection is poor and the National Health Accounts' estimates indicate that out-of-pocket (OOP) expenditure share of the total health expenditure was 55 percent in 2009,⁸ majority of which was on drugs provided for out-patient care. As a result of the high OOP and as a consequence of payments to health care, an estimated 6.7 percent of households fall into poverty in a given year.⁹

8. Weaknesses in health systems and public sector management inefficiencies contribute to the low quality of care and inequities in health outcomes. Various binding constraints contribute

⁶ Nepal Central Bureau of Statistics and UNICEF, "Nepal Multiple Indicator Cluster Survey 2014 Key Findings."

⁷The Ministry of Health and Population (MoH) Nepal, Health Research and Social Development Forum, and Nepal Health Sector Support Program. 2014. Service Tracking Survey 2013. Kathmandu, Nepal.

⁸The Ministry of Health and Population 2012; National Health Accounts 2006/7–2008/09.

⁹ The figure is computed using a poverty line of US\$1.25 per capita per day. See World Bank 2012 Health Equity and Financial Protection Datasheet – Nepal. Washington, DC.

to poor public sector management in health. These include: weaknesses in public financial management, poor resource allocation to sector priorities, deficit of qualified health workers and inefficiencies in human resource management, inadequate oversight by the MoH due to low capacity, weak information systems from decentralized units where service delivery occur, poor accountability at most levels, and inadequate and fragmented mechanisms for citizen engagement despite being a key priority area under the MoH's GESI strategy.

9. The effects of these weaknesses manifest in the following ways:

- a. *A deficit of qualified health workers in various health facilities, primarily because of inefficient cadre management and the political economy of human resource management which leads to inability to fill posts in remote areas.* Strategies to enhance an appropriate skill-mix and equitable distribution of professional and support staff, especially in remote areas, and their retention, will be crucial for Nepal to realize its agenda of UHC.
- b. *Weaknesses in public financial management.* Inadequate resource allocation to sector priorities undermines the achievement of equity and access to essential services. Sector budget formulation processes remain ad hoc, and largely uninformed by inputs from decentralized units and facilities where service delivery occurs. Poor accounting systems have led to poor expenditure tracking and weak accountability.
- c. *Fiduciary integrity remains a major challenge.* The system of internal controls needs to be substantially strengthened to reduce the risk of resources not being used for their intended purpose, misappropriation of assets, and poor value for money in the procurement of essential commodities and equipment.
- d. *Low accountability for results at all levels.* This is evidenced by weak planning and monitoring for evidence-based decision making. Current patterns of public spending do not particularly benefit the poorest and most marginalized populations/districts.
- e. *Limited institutionalized citizen engagement mechanisms for holding policy makers and providers accountable for service provision.* The GESI strategy, which was developed during the Nepal Health Sector Program 2 (NHSP 2), enables strengthened citizen engagement (by providing citizens with the information and capabilities they need to access a given service; and capturing information from citizens, via voice and feedback). However, implementation of the strategy has been limited as a result of which demand-side accountability has remained weak.

2.3 Nepal Health Sector Strategy (NHSS)

10. The Nepal Health Sector Strategy 2015-2021 (NHSS), under the auspices of National Health Policy 2014, is the primary instrument to guide the health sector for the next five years. It adopts the vision and mission set forth by the National Health Policy and carries the ethos of Constitutional provision to guarantee access to basic health services as a fundamental right of every citizen. It articulates nation's commitment towards achieving UHC and provides the basis for garnering required resources and investments.

11. The NHSS has four strategic principles:

- i Equitable access to health services
- ii Quality health services

- iii Health systems reform
- iv Multi-sectoral approach

12. The NHSS incorporates institutional and systemic reforms alongside a renewed focus on delivering more effectively and efficiently so that the poorest and most marginalized populations access services. It envisions for equitable service utilization, strengthening service delivery and demand generation to underserved populations, including the urban poor and calls for greater partnerships with local level institutions and community groups to empower women, promote supportive cultural practices and curb gender-based violence in the society. There is a strong focus on improving institutional arrangements that affect service delivery—including human resources, procurement, contract management systems, budget planning, execution and reporting, as well as expanding citizen engagement to create better transparency and accountability. It also focuses on ensuring that services and financial protection mechanisms are targeted to populations in greatest need.

13. The NHSS was developed within the context of Sector Wide Approach (SWAp) and it sees partnership as a cornerstone for health development in Nepal. NHSS was developed jointly by the GoN and its development partners. These included the World Bank, U.K. Department for International Development (DFID), GAVI, KfW, and DFAT were pooled partners through a common financing mechanism. The United Nations Children’s Fund (UNICEF), World Health Organization (WHO), United Nations Population Fund (UNFPA), U.S. Agency for International Development (USAID), and German Agency for International Cooperation (*Deutsche Gesellschaft für Internationale Zusammenarbeit*, GIZ) financed/provided technical assistance (TA) to the health sector program in parallel, through their own financing mechanisms. Ten years of this partnership has supported Nepal in achieving the health MDGs.

SECTION II: PROGRAM DESCRIPTION

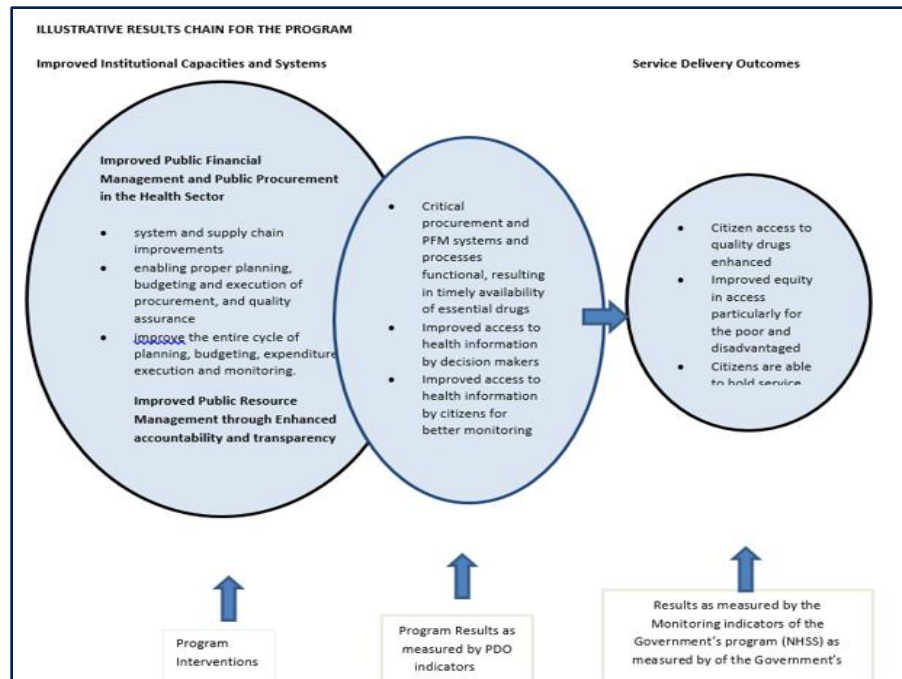
3.1 The Program for Results (PforR) operation

14. The Program for Results (PforR) will support a subset of the larger Nepal Health Sector Strategy (NHSS-2015-2021) which outlines the GoN program towards achieving its goal of universal health coverage. The government's reform program recognizes that improved health outcomes hinge on the ability of the MoH to direct public resources to areas of need, and to react to and make evidence-based decisions. The Program boundaries of the PforR will include those outcomes/sub-outcomes of NHSS which focus on strengthening supply and demand side constraints of institutional performance to support more efficient use of resources for targeted and better service delivery over time. Therefore the scope of the PforR has been defined with reference to the following Outcome/Result areas of NHSS:

- Outcome 1: Rebuilt and strengthened health systems: Procurement and Supply chain management (excluding procurement of goods and pharmaceuticals and construction/civil works.
- Outcome 4: Strengthened Decentralized Planning and Budgeting
- Outcome 5: Improved Sector Management and Governance
- Outcome 6: Improved Sustainability of Healthcare Financing
- Outcome 9: Improved availability and use of evidence in decision-making processes at all levels

15. The Program Development Objective (PDO) of the PforR is to improve efficiency in public resource management systems of the health sector in Nepal.

16. The PforR focuses on specific NHSS outcomes in critical areas of policy and institutional reforms to be achieved through government ownership and action. The PforR recognizes that establishing rigorous institutional systems and sound accountability mechanisms requires long-term changes in process and institutional culture. Therefore it focuses on improving the capacity of the MoH to manage public procurement and establishing mechanisms for logistics management and quality assurance. At the same time the Program also supports better planning and targeting through strengthening data availability and analysis. Demand side accountability mechanisms will be strengthened to integrate citizen engagement into the process of public governance. Together, these inputs will support more efficient use of resources for targeted and better service delivery over time. This theory of change is illustrated through the Results Chain in Figure 2.



3.2 Program Development Objective and Key Results

3.2.1 Program Development Objective

17. The Program Development Objective (PDO) is to improve efficiency in public resource management systems of the health sector in Nepal.

3.2.2 Key Program Results

18. Progress toward meeting the PDO will be assessed using the following indicators:

- Percentage reduction of stock-outs of tracer drugs;
- Percentage of the Ministry of Health's annual spending captured by the Transaction Accounting and Budget Control System (TABUCS); and
- Percentage of facilities reporting annual disaggregated data using the District Health Information System 2 (DHIS 2).

3.2.3 Disbursement-linked Indicators

19. The PforR operation supports the Program through a series of DLIs which form the basis for disbursement. There are a total of 11 DLIs which focus on critical aspects of health sector management including priority areas in procurement and public financial management in the health sector and reporting and information management for better evidence based planning. The achievements of these DLIs will support NHSS to achieve its Outcomes 1,4,5,6 and 9 and establish a robust institutional framework for public management, accountability and transparency in the health sector. Linking payments to results promotes transparency and accountability in the system thereby reducing leakages. The DLIs are also strongly aligned with GON priorities and allow for a regular disbursement flow. The DLIs are achievable and challenging at the same time so that the

financial risk attached to each DLI will have the appropriate impact. (Table of DLIs is provided in Annex II)

3.2.4 Institutional And Implementation Arrangements

20. **The MoH will be responsible for implementing Program activities** through its various organizational structures including its departments, divisions, and centers. **A DLI Management and Coordination Unit at the MoH**, chaired by the chief of the Policy, Planning, and International Cooperation Division (PPICD), will support implementation of the Program. There will be a Program Steering Committee, which meets quarterly, chaired by the secretary of the MoH, and include the director general, Department of Health Services (DoHS); chair, PPICD; the head of Human Resource and Financial Management Division; and representatives from the MoF. The Steering Committee will provide overall guidance, resolve Program specific issues, and ensure inter-ministerial and sectoral coordination. Day-to-day implementation and monitoring of results in the four key areas will be the responsibility of the heads of the following divisions:

- a. Logistics Management Division (LMD) for procurement related DLIs;
- b. Human Resources and Financial Management Division for public financial management related DLIs;
- c. Management Division, DoHS for M&E and DHIS 2;
- d. Primary Health Care and Revitalization Division, for citizen engagement.

21. Environmental issues related to the health sector and waste management are currently under the responsibility of the Management Division of the DoHS and the Curative Division of the MoH; while the Monitoring and Evaluation Department in MoH is responsible for monitoring. Under the Program, responsibility for the implementation of the ESSA action plan will be assigned to a DLI Management and Coordination Unit at the MoH. This can be done in collaboration with Management Division of DoHS and Curative Division of MoH.

SECTION III: NATIONAL ENVIRONMENTAL AND SOCIAL MANAGEMENT SYSTEMS

5.1 Institutional framework:

5.1.1 Government Agencies:

23. The main Government institutions with key responsibilities for environmental and social management in the health sector are described below.

a) Ministry of Health (MoH)

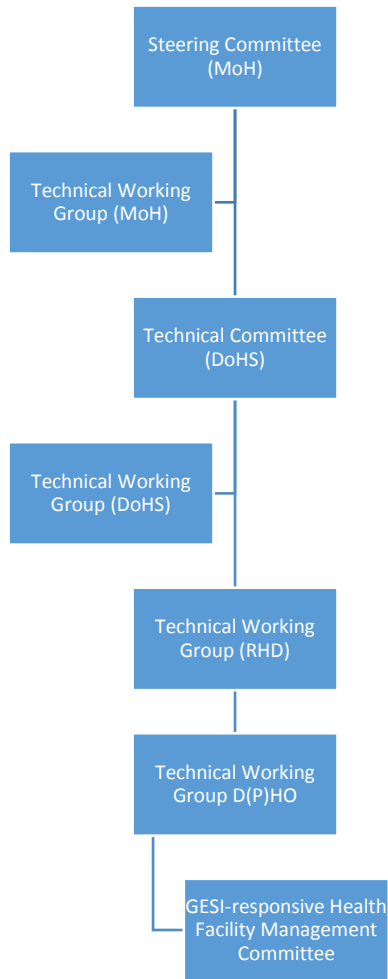
24. The MoH plays a pivotal role in improving the health of the people including mental, physical and social well-being, for overall national development with the increased participation of the private sector and non-government institutions in the implementation of programs. The MoH is also responsible to make necessary arrangements and formulate policies for effective delivery of curative services, disease prevention, health promotive activities and establishment of a primary health care system. Under the Ministry, there are departments and units such as the Departments of Health Services (DoHS), Department of drug-administration and semi-autonomous agencies and regulatory bodies which includes councils (such as Medical and research council) and Academy /medical colleges and centralized/special hospitals etc. There are six divisions within the MoH, which are: (i) Policy Planning and International Cooperation; (ii) Curative Services; (iii) Public Health and Monitoring and Evaluation; (iv) Human Resource and Financial Management; (v) Administrative and (vi) Population Division.

25. There is no separate unit/cell within the Ministry nor at the departmental or hospital level with the responsibility for overseeing the overall environmental issues relating to the health sector. The DoHS is the department which looks after District Hospitals and below facilities. The Management Division within the DoHS has the mandate to monitor program implementation status and carry out periodic performance reviews which includes health care waste management. Capacity building and training are the responsibility of the Management Division.

26. At MoH, there are the following provisions for GESI as per the 'Institutional Structure for Establishment and Operational Guidelines:

(a) **GESI Steering committee** at the ministry level which is responsible for mainstreaming GESI in the health sector, and take the lead role in institutionalizing GESI in the ministry, departments, district and regional levels and health facilities. The Chief of the Population Division functions as the GESI Focal Person for the entire MoH.

(b) **GESI Technical Working Groups (TWGs)** are responsible for implementing GESI-related activities and mainstream GESI in the divisional programs. This TWG is formed with the representation of six officer-level focal persons from the MoH, who are responsible for institutionalizing GESI within their respective divisions.



(c) **GESI Technical Committee (TC) at the DoHS:** Its main responsibility is to institutionalize and mainstream GESI in the department and implement GESI strategy effectively from department to local health facility level. Its activities include conducting a GESI audit of health programs and make the programs/activities GESI-responsive; prepare action plan for the implementation of GESI; lead the capacity development of health service providers and managers on GESI; review and recommend solutions on GESI-related issues; establish a GESI TWG in the DoHS, and to determine its scope of work and responsibilities; support the establishment and strengthening of GESI TWGs in the Regional Health Directorates (RHDs); work in close coordination with the GESI SC Secretariat (at the MoH) and provide an annual GESI progress report to the Steering Committee.

(d) **GESI Technical Working Groups at the DoHS:** The TWGs are responsible for institutionalizing and mainstreaming GESI in the divisions and centers. They are responsible for including the recommendations of the RHD TWGs and the GESI-related recommendations of the regional-level annual review meetings into the Annual Work Plan and budget of the DoHS; support the implementation of annual programs in a GESI-sensitive manner; and review the progress, issues, and challenges in GESI mainstreaming and formulate necessary strategies

accordingly.

(e) **Technical Working Groups at Regional Health Directorates (RHDs):** The TWGs established at RHDs are responsible for preparing and implementing the GESI action plans; providing technical and coordinating support for the implementation of major GESI-related programs, e.g. the Equity and Access Program, One-stop Crisis Management Centres, Social Service Units, social audit etc.; mainstreaming GESI in health programs, and providing technical support to District Health Offices (DHOs)/District Public Health Offices (DPHOs) in the design and implementation of targeted programs in order to reach unreached regions and underserved groups. They also support the capacity development of health service providers and managerial staff in the matter of GESI mainstreaming; support DHOs/DPHOs in the formation and strengthening of the GESI TWG; work in close coordination with the GESI TC at the DoHS and provide trimesterly and annual GESI progress reports to the TC through the Primary Health Care Revitalization division under the DoHS; hold an annual regional review meetings and plan workshops relating to GESI at the RHD and DHO/DPHO levels.

(f) **Health Facility Operation and Management Committee (HFOMC)** is responsible for acting as a GESI TWG at the health facility level. HFOMCs are

responsible for mainstreaming GESI in all its activities and services; and acting as a bridge between service providers and the community especially in terms of ensuring reliable, equitable, and good-quality services to the community. The of health facility in-charge is the GESI Focal Person. Specifically, the responsibilities of HFOMC with regards to GESI include: identify unreached areas and groups, and to facilitate and improve their access to available health services; identify the issues and problems of women, the poor, and other excluded groups by coordinating with Female Health Workers and social mobilisers, and to advocate for addressing these problems to the concerned health/other institutions; coordinate with the VDC, Integrated Planning Committee, Ward Citizen Forum, and other concerned institutions in order to improve access to and utilization of health services by women, the poor, and other excluded groups; and work through social mobilisers to improve the health seeking behavior of women, poor and other excluded groups and monitor change in the health indicators of these groups.

(g) **Technical Working Groups at the DHO/DPHO:** The TWGs are responsible for operationalizing effectively the GESI Strategy at the DHO/DPHO, district hospitals, and local health facilities with the objectives of mainstreaming GESI in health programs; coordinating with RHDs, HFOMCs, health personnel, and other concerned district-level health agencies in matter concerning GESI, and sharing experiences and learning on the same.

b) Nepal Health Research Council (NHRC)

27. The NHRC, an apex body, was established to promote scientific study and quality research on health problems in Nepal. The council under the jurisdiction of MoH have the objectives to develop the national health research agenda through needs assessment, and develop strategies and priorities to strengthen the network, coordination, and monitoring in health research, to promote good ethical practice in health research in networking institutions, to disseminate and utilize research findings, to facilitate development research initiative among different level of health cadres and provide training program etc. NHRC has been involved with WHO in drafting the first HCWM guidelines with the aim to help health care institutions to develop sound health care waste management system. The guidelines were successful in sensitizing the government, health care institutions, policy makers, planners, and civil society of Nepal.

c) Nepal Medical Council

28. Nepal Medical Council has been established under the MoH and is an autonomous and corporate body having the mandate to manage qualification of medical practitioner and also registration of Medical practitioner qualified in modern medicine for the scientific utilization of modern medicine throughout the Kingdom of Nepal. This council gives accreditation as prescribed to the Medical/Dental College engaged in teaching training of medical education and prepare code of conduct of the Medical practitioner and also actively participates in making National Health Policy.

d) Nepal Nursing Council

29. Nepal Nursing Council under the jurisdiction of MoH is also an autonomous and corporate body established under Nepal Nursing Council Act 2052 (1996). The main functions is to determine the qualifications of the nursing professionals and to issue certification and registration to the qualified

nursing professionals, formulate policy required to operate the nursing profession smoothly, provide recognition to a teaching institution, and formulate professional code of conduct of the nursing professionals and to take action against those nursing professionals who violate such code of conduct.

e) Ministry of Population and Environment (MoPE)

30. The Ministry of Population and Environment (MoPE)¹⁰ has a mandate to implement Environment Protection Act 2053 and Environment Protection Regulation 2054, Environmental Guidelines, Standards and Directives issued by GoN. The Department of Environment (DoE), one of the leading departments is responsible for harmonizing the environmental activities that complies with international obligations. It is primarily responsible for the formulation and implementation of policies, plans and programs; preparing Acts, Regulations and Guidelines; conducting surveys, studies and research, disseminating information and carrying out publicity; monitoring and evaluating programs; developing human resources and acting as a national and international focal point for environmental issues. The scope of work on environment involves current environmental issues, National Conservation Strategy, Nepal Environmental Policy and action Plan and functions relating to promote sustainable development, preserve the quality of environment — including air, water and soil. The MoPE is the legally mandated agency for approving and giving clearances to EIAs and is currently in the process of drafting the HCWM Regulations, as per the Supreme Court verdict of 2012.

f) Ministry of Federal Affairs and Local Development (MoFALD)

31. MoFALD plays the role of coordination, cooperation, facilitation and monitoring and evaluation of activities undertaken by local bodies and contributes to poverty reduction by mobilizing local means and resources, utilizing skill and technology to the optimum level and creating employment opportunity. Besides this, it also does the capacity building of local government through local self-governance and contribute to promote local good governance. As per the Government of Nepal (Allocation of Business) Rules, 2012 the MoFALD is responsible for formulation, implementation, monitoring and evaluation of policy, plans and programs relating to sewerage and sanitation

32. Under the jurisdiction of MoFALD, the Solid Waste Management Technical Support Centre (SWMTSC) is responsible for providing technical support to manage solid waste properly and in an environment-friendly manner. The SWMTSC, chaired by the Minister of Local Development, is the lead technical agency for Nepal's Solid waste management sector and is responsible for formulating policy pertaining to solid waste management. It supports solid waste management efforts of municipalities but does not directly undertake solid waste management operations.

g) Ministry of Urban Development (MoUD)

33. MoUD has the mandate to develop and manage basic urban infrastructure services such as housing and solid waste Management. It also carries out specialized functions such as urban and regional planning, urban development, new towns and government buildings. Generally, MoUD

¹⁰ The Environment Division was recently separated from the earlier Ministry of Science, Technology and Environment (MoEST) and has been merged with Population to create Ministry of Population and Environment (MoPE) which focuses on environmental conservation, pollution prevention and control, and conservation of national heritage as well as the effective implementation of commitments expressed in regional and international levels.

performs these functions collaborating with the local bodies. MoUD operates through its implementing arms -Department of Urban Development and Building Construction and about 16 other different organizational entities including Town Development Fund. The MoUD furthermore keeps oversight on regional planning authority like Kathmandu Valley Development Authority (KVDA) and 197 Town Development Committees (TDCs). The two ministries MoFALD and MoUD tend to undertake complementary functions in the same urban space but institutional coordination mechanisms linking these two ministries remain lacking.

h) Ministry of Water Supply and Sanitation (MoWSS)

34. The GoN established this new Ministry on 24 December, 2016 as the lead executing agency of the Water, Sanitation and Hygiene (WASH) sector. The main scope of its work is to formulate policies related to water supply and sanitation, formulate plans and programs, implement, monitor, and evaluate works related to water supply and sanitation. The Department of Water Supply and Sewerage (DWSS) under this Ministry, is the lead implementing agency of the WASH sector with responsibility of planning, implementation, operation, repair and maintenance of water supply and sanitation systems throughout the country. Additionally, there are Boards, Water Supply Corporation, Committees, Project Directorate and Water Tariff Fixation Commission as regulatory body for the urban water and sanitation services delivery

i) Kathmandu Municipal Corporation (KMC)

35. The Kathmandu Municipal Corporation (KMC) is the chief nodal agency for the administration of Kathmandu, which is divided into five sectors: Central, East, North, West and the City Core. For civic administration, the city is further divided into 35 administrative wards, and the KMC does its administration through 177 elected representatives and 20 nominated members, under a Chief Executive Officer. It holds biannual meetings to review, process and approve the annual budget and make major policy decisions. Due to political failures and inability to conduct local-level elections, KMC is being run by civil servants in lack of elected representatives.

36. The KMC has eleven departments which delivers/provides various type of services to the citizens of Kathmandu. The Environment Department has the responsibility as a regulator and manager of municipal solid waste. Its other mandates include park management, maintaining greenery and training/awareness raising with regard to solid waste management and environment. The major challenge for this Department is meeting the demands for solid waste collection, transfer and disposal within its financial, technical and managerial resource limitations. The KMC runs Sisdole dumping site which is about 26 km from Kathmandu. There are also several private companies and NGOs working in the area of municipal solid waste collection. The KMC had initiated infectious medical waste projects 15 years back, including procurement of vehicles and incinerator, but was not sustained. Currently the KMC collects disinfected/treated hospital waste which is then disposed in the municipal waste dumpsite.

j) Kathmandu Valley Development Authority (KVDA)

37. The KVDA was established in April 2012 with the vision to develop “Kathmandu Valley as a Safe, Clean, Organized, Prosperous and Elegant National Capital Region so as to foster the global image of Kathmandu Valley as a livable city with the synergy and harmonization of nature, society and culture. Its primary mandate is to prepare and implement an integrated physical development

plan for Kathmandu Valley, which encompasses five municipalities and 99 village development councils¹¹. One of its priorities is to coordinate the activities of multiple agencies involved in services like land administration, drinking water, sewerage and waste management, road, communication, electricity etc., which constitute critical aspects of urban development.

5.1.2 Other Stakeholders

38. *Health Care Foundation-Nepal (HECAF)*, established in 1997, is a not-for profit organization dedicated to providing health care services to common people of both rural and urban areas. It is also actively involved in issues that are directly or indirectly related to the health of common people such as environmental pollution, infectious and solid waste disposal, lack of pure drinking water, misuse of medicines and other harmful activities. It has been launching public awareness campaigns and conducting or promoting subject specific studies and research in the field.

39. *Environment and Public Health Organization (ENPHO)* is a service-oriented national Governmental Organization (NGO), established in 1990 that envisages contributing in sustainable community development by combining research and actions through the integrated programs in the environment and public health areas. It runs a government accredited laboratory for environmental monitoring and analysis and is actively involved in promoting eco-friendly technologies.

40. *Society for Healthy Environment & Women Development (SHEWD)* is a small, grassroots NGO in Nepal that provides healthcare and training to residents of deprived rural areas living on less than 1 USD a day. Their projects focus on job creation and the empowerment of women and their healthcare programs focus on eye care clinics and other projects.

41. *National Health Training Centre (NHTC)* under DoHS is responsible for meeting the training needs for quality health care delivery throughout the country. The NHTC has been providing basic health trainings, specialized trainings, clinical trainings, etc., to a variety of health care providers and administrators in the health sector from national to local levels.

42. Private Waste Management Operators

Kathmandu Municipality Corporation (KMC) has been trying to involve Private Sector Participation for management of solid waste management especially for efficient collection system, efficient transfer and scrap recovery, maximum recycling & composting, sanitary landfilling, special waste management and public education and participation etc. Currently, there are two Nepali companies like Nepwaste and Clean Valley Company to manage the Kathmandu Valley's garbage which are in the process of being engaged for solid waste management in parts of Kathmandu. Nepwaste will implement the project in Kathmandu and neighboring village development committees while Clean Valley will work in Lalitpur, Kirtipur, Bhaktapur, Madhyapur Thimi and adjoining village development committees.

5.2 National Policy and Legislative Framework

¹¹The permanent population is estimated to be three million and floating population of two and a half million people.

43. Nepal has a number of policies, instruments and laws that support environmental and social management and the environmental and social assessment processes. Besides the constitutional right to live in a clean environment (Constitution of Nepal, 2015, Part 2, Section 23), the GoN has enacted various Acts and Regulations relating to clean environment, public health protection, and health care waste management. These include:

5.2.1 Existing Legal provisions relating to Environment

a) *Environment Protection Act 1997, Environment Protection Regulations 1997 (amended 1999, 2007, 2009 and 2010):*

44. This is the main legislation guiding environmental management in Nepal. Under section 7 of the Act, industries or any others development project owners are required not to discharge, emit or dispose waste, sound, radiation or any such acts which will cause pollution or to allow pollution to be caused in a manner which is likely to have significant adverse impacts on the environment or to harm human life or public health. Further, the section stipulates that causing pollution or allowing such pollution to be deemed a punishable act. Section 10 of the Act prohibits any activity without the approval in the environmentally protected areas declared by GoN. Section 17 of this Act is concerned about compensation. In case of pollution, creation of disposal, sound, heat or wastes by anybody contrary to this Act, any person or organization that suffers any loss or damage, may, if she/he desires, have compensation recovered from the person, institution or proponent doing such an act. Rule 14 provides that the MoPE to be responsible for environmental audit after two years of project implementation. Sections 11 and 12 include provisions relating to laboratory establishment and collection of samples. Similarly, Section 16 allows for committee formation, and Sections 23 and 24 has provisions to frame guidelines and rules, respectively, as required.

b) *Solid Waste Management Act, 2011 and Solid Waste Management Rules, 2013:*

45. Sufficient definition of medical waste was included for the first time in the Solid Waste Management Act. Chapter 2.4 states that the producer is responsible for the treatment and proper management of medical waste. Only after treatment can such waste can be disposed in sanitary landfill site with mutual agreement with local government authority. Chapter 7 has a provision for forming a Council to formulate required policy document, and the Secretary from MoH is required to be one of the members of the Council. Section 6 mentions measures relating to discharge and management of health institution related waste. In particular, it states that health care waste should be treated and disinfected into general waste before disposal/landfill. The Act states that until the health institutions comply with the standards for medical waste management, the concerned government body will not grant a license of operation.

c) *Health Care Waste Management Regulation (Draft), 2015:*

46. Based on a Supreme Court verdict issued in 2012, the MoPE developed HCWM regulations in 2014. Several focus group discussions were held with various stakeholder and concerned ministries like MOH, Ministry of Federal Affairs and Local Development (MoFALD) and Ministry of Urban Development (MoUD) provided comments to the draft. One round of discussions were held within the Secretaries of line Ministries - MoFALD, MoUD, MoH and MoPE after which the draft was forwarded to the Ministry of Law for endorsement. A decision to forward this regulation for Cabinet approval is still under consideration.

47. The regulation hinges on the Environmental protection Act, 1997. The health facilities which come under this regulation include all type of health facilities including pharmacy, diagnostic center, research center, medical college, teaching hospital and also private facilities. Disposal of hazardous waste is the responsibility of generator/health facilities. Their main obligations are i) adopting mechanisms for reducing the volume of HCM waste and ii) segregation, collection, proper transportation, management and disposal of waste. The regulation also has made provision for coordinating with the local waste management body for disposal of segregated waste. The regulation prohibits the discharge of the liquid waste in the public sewer lines and enforces internal management for the same. Provision for involving the private sector in the management of waste including recycling, disposal, transportation and selection of site for disposal has been mentioned. The draft regulations define technology options and requirements for provision of PPE for the healthcare staff training programs and dissemination of information and monitoring.

d) Health Care Waste Management Guidelines, 2014

48. The NHRC, in collaboration with MoH issued these guidelines in 2014. It details good practices associated with waste segregation, treatment and waste management technologies at the facility level. Details about waste disposal processes, institutional arrangements including enforcement, multi-agency coordination and budgetary allocation are not explicitly defined in the guideline. A Training Manual for Medical Professionals was also developed.

e) Standards for the construction of new health facilities¹²

49. These standards, developed by the MOH, cover 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 signages etc. while also including aspects related to accessibility for differently able people road connectivity etc. The standards include guidelines for disinfection and disposal of infectious and chemical liquid waste and also includes designs for septic tanks, soak pits, ramps, lifts, doors, toilets and other details.

f) Hazardous Waste Management Policy (Draft), 2010:

50. The draft document lists clinical wastes from hospitals, medical centers and clinics as a Hazardous Waste (Annex 1).

g) National Health Policy, 2014

51. Sections 11.1 and 11.2 of the Policy mention environmental protection and making provisions for proper scientific management of health care waste.

h) Local Self-Governance Act, 1999:

52. The Act is the main legislation governing the activities of municipalities, and mandating their responsibility for waste management and control of water, air and noise pollution. Local government bodies are also empowered to fine anyone for haphazard dumping of solid waste. However, the issue of hazardous waste is not addressed in any clauses in the Act.

i) Labor Act, 1991:

¹² Standard Guidelines for Post-Disaster Reconstruction of Health Buildings: Government of Nepal Ministry of Health and Population 2015

53. This Act focuses on the regulation of work environment, including issues relating to occupational health and safety. The Act is administered by the Ministry of Labour and Employment (MoLE) and requires generators to make arrangement for removal of waste accumulated during production process and prevention of accumulation of dust, fumes, vapors and other materials which would adversely affect the health of workers. Issues related to occupational safety of workers and medical professionals are addressed in the HCWM specific guidelines.

j) *Town Development Act, 1988*

54. Clause 9 of the Act empowers the Town Development Committee to regulate, control or prohibit any acts/activities which has an adverse effect on public health or the aesthetics of the town, or in any way pollute the environment. It contains provisions for fines for violation of the Act.

k) *Pesticide Act, 1991 and Pesticide Regulations, 1994*

55. The Act makes it mandatory for a person or organization to acquire a certificate of registration before the import, export, use, sale or purchase of pesticides. It has made a provision to appoint pesticide inspector to monitor compliance with the law and thus regulates the hazardous substance as a potential hazardous waste.

l) *Health Care Institution Establishment, Operation and Upgrading Guidelines, 2014*

56. This guideline was prepared under the provision of Good Governance (Management and Operation) Act, 2006. Section 2, Clause 3.2 mentions the need of assurance for environmental management along with health care waste management prior to establishing and operating a hospital. Section 4, Clause 16 contains provisions on hospital related infrastructure standards and requires them to have suitable technology and proper infrastructure to manage hazardous waste. Clause 16.9 also details procedures for managing medical waste. Clause 17(b) mentions that a separate waste management plan should be prepared by the sanitation unit and an environmental expert for a hospital above 100 bed capacity. Clause 28 of Section 11 indicates the non-renewal of hospital operation licenses if recommended environmental measures have not been implemented and there is lack of proper management of health care waste.

m) *Urban Environmental Management Guidelines, 2011*

57. Section 6 of the guidelines state that hazardous waste generated from hospital activities must be categorized/classified and managed as per the provision stated by the HCWM Guidelines. It requires institutions to specify the responsible departments/designated body for the management of hazardous health care waste and provide trainings to those involved in waste management. The municipality can provide support to the concerned institution bearing the associated costs.

n) *Right to Information Act, 2004 (2007)*

58. This Act requires Public Bodies to respect and protect the right to information of citizens. Public Bodies are responsible to make citizens' access to information simple and easy, to classify and update information and make them public, publish and broadcast, to conduct its functions openly and transparently, to provide appropriate training and orientation to its staffs, Public Body may use different national languages and mass media while publishing, broadcasting or making information public in accordance with Section (a) of Section (2). Public Body shall arrange for an Information Officer for the purpose of disseminating information held in its office. There shall be

an independent National Information Commission for the protection, promotion and practice of right to information.

o) Governance (Management and Operation) Act, 2005

59. This is a full-fledged legal arrangement on citizen charter, through which various aspects of the charters gained a wider spectrum of legitimacy. Article 25 has made it mandatory to put citizen charter publicly in front of every public offices.

5.2.2 Existing Legal provisions relating to Social

a) National Legal and Policy Framework Relating to GESI

60. To improve the access of disadvantaged and marginalized groups to basic and quality health care services; policy makers, international partners, political actors and NGOs (especially after the political change in 2006) have expressed strong commitments to gender equality and social inclusion. Accordingly, the issue of Gender and Social Inclusion has been brought to the fore in development discourses, and also reflected in various acts, policies, strategies and programs, including in the health sector. (see below)

b) Constitution of Nepal, 2015

61. Article 35 of the Constitution of Nepal, 2015 describes, 'Every citizen shall have the right to seek basic health care services from the state and no citizen shall be deprived of emergency health care.' Additionally, it states that 'each person shall have the right to be informed about his/her health condition with regard to health care services, each person shall have equal access to health care and each citizen shall have the right to access to clean water and hygiene.

c) National Foundation for Upliftment of Adivasi/Janjati Act, 2002 (2058)

62. This Act is one of the key legislative frameworks in Nepal relating to indigenous nationalities. The Act has identified and legally recognized 59 indigenous communities. They are officially referred to as *Adivasi/Janajati (Indigenous Nationalities)*. According to Nepal Federation of *Adivasi/Janajati* (NEFIN) 10 of the 59 *Adivasi/Janajati* are "endangered", 12 "highly marginalized", 20 "marginalized", 15 "disadvantaged" and 2 are "advanced" or better off on the basis of a composite index consisting of literacy, housing, landholdings, occupation, language, graduate and above education, and population size.

d) Local Self-Governance Act, 1999 (2055)

63. Different sections of the Local-self Governance Act (LSGA) requires peoples' participation in local governance and while designing programs and plans at the local level. In formulating plans, the LSGA states, "the Village Development Committee shall have to give priority to the local people, especially targeting benefits to women, children, and marginalized communities." Likewise, in selecting projects, it is required that the local governments ensure utmost participation of the local people. In short, local governments are required to create conducive environment for the utmost participation of local communities in the process of governance by way of decentralization.

e) Right to Information Act, 2007 (2064)

64. Right to Information Act, 2064 (2007) makes the government agencies accountable to the citizens of Nepal. The Act states that all public authorities are required to respect and protect the right to information of all citizens and make access to information easy and accessible. It also authorizes government bodies to protect sensitive information that could have an adverse impact on the interest of the nation and citizens. Clauses 3, 4, and 7 ensure the rights of citizens to information, including by defining the responsibilities of the public body to disseminate information and procedure of acquiring information respectively.

f) Caste Based Discrimination and Untouchability (Offence and Punishment) Act, 2011 (2068)

65. The Act has made any practices of discrimination and untouchability at both in 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.

g) Domestic Violence (Crime and Punishment) Act, 2009

66. The Domestic Violence (Crime and Punishment) Act, has defined physical, mental, sexual, financial as well as behavioral violence as domestic violence. The Act includes physical and psychological violence within the definition of domestic violence. The Act also states that the reporting of the crime can be made both verbally or in writing. If the case does not get resolved through quasi-judicial bodies or mutual understanding, the victim can file a case directly to the courts. Furthermore, a third party can also file a report on behalf of the victim. It has also made provisions for interim relief to the victim of the domestic violence. The court can order interim protective measures for the entire duration of case proceedings.

h) Gender Equality Act, 2006

67. The Gender Equality Act, 2006, repealed and amended 56 discriminatory provisions of various previous Acts and also incorporated provisions to ensure women's rights. Some key provisions amended by the Act are the provision that a daughter is required to return shared property upon marriage, the provision for summons issued by the court to be received by a male family member as far as possible and the provision for divorce in the case of not having children within 10 years of marriage. Further, the Act establishes sexual violence as a crime punishable by varying years of imprisonment, depending on the age of the victim.

i) Gender-Related International Conventions

68. Nepal has committed itself to important international conventions 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), all of which have a strong gender dimension.

j) ILO Convention on Indigenous and Tribal Peoples, 1989 (No.169)

69. 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, 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.

k) GESI in Health Plans and Policies

70. In the health sector, the GoN has been formulating and implementing various policies and programs such as the Second Long-term Health Plan 1997-2017; Health Sector Strategy 2004; the Nepal's Health Sector Program-Implementation Plan 2004-2009; Vulnerable Community Development Plan 2004, Ten-Point Health Policy and Program 2007; and the Free Health Service Program, 2007/08, all of which have focused on improving the health status of disadvantaged and marginalized populations. Additionally, in the National Health Policy 2015, the GoN has expressed its commitment and responsibilities towards improving the access and outcomes of disadvantaged communities in the health sector (GoN, 2014; 2015).

71. The GoN has also issued some key guidelines and strategies on GESI such as the Health Sector GESI Strategy 2009; the Operational Guideline for GESI Mainstreaming Strategy in Health Sector 2013; and the GESI Operational Guideline 2013, Institutional Structure for Establishment and Operational Guidelines for GESI 2013, all of which are aimed at improving the access and use of health services by disadvantaged and marginalized groups. Specifically, these guidelines emphasize creating a favorable environment, enhancing capacity of service providers, improving the health-seeking behavior of disadvantaged populations based on a rights-based approach, ensuring adequate budget and monitoring arrangements, GESI responsive reporting, and effective governing and implementation of health services including from the private and non-state actors.

SECTION IV: POTENTIAL ENVIRONMENTAL AND SOCIAL IMPACTS OF THE PROGRAM

Environmental Risks and Opportunities of the Program

6.1 Data and Findings

72. A study conducted in a hospital in Kathmandu in 2014 found that the prevalence of bacteria causing nosocomial infection was 34.4 percent¹³ higher than the similar studies in other hospitals from different countries (13%-17.8%). Out of 310 specimens, three hundred thirty three bacteria were isolated, of which the most common isolates were *Escherichia coli* (primary cause of urinary tract infections or other infections), followed by *Acinetobacter* species, *Klebsiella pneumoniae* and *Staphylococcus aureus* (all resulting in different types of infections).

73. Water, sanitation and hygiene related ailments and diseases are the 10 most prevalent diseases in Nepal. Over one in six (16%) hospitals and clinics do not have access to clean water and nearly a third (29%) do not have safe toilets. Eight out of ten (81%) do not have soap or hand washing facility¹⁴. It has been found that even if hospitals and clinics are defined as having access to clean water, the water supply may be up to half a kilometre away from the facility rather than piped into the premises. Additionally there is limited data as to whether toilets in healthcare facilities are in working order and can be used by both staff and patients. In Nepal one woman in every 96 on average loses a baby to infection during her lifetime compared to one in 7,518 in the UK¹⁵.

74. Another survey of 17 hospitals in Kathmandu undertaken in 2013¹⁶ found that there has been some improvement since 2003 in infection control and use of personal protective equipment (PPE) including surveillance based on the results of bacteriological testing. However, the major problems identified included increasing bacterial resistance to antibiotics, inadequate management of infection control, insufficient training inadequate essential equipment.

75. The MoH estimates 13,613.5 tons of waste are generated by health institutions across the country every year, of which up to 25 percent are hazardous¹⁷. About 28.47 kg biomedical wastes are generated by 301 private hospitals across the country. The report showed that majority of the hospital wastes were segregated in various bins while their disposal was municipality collection center. Hospitals are responsible for disposing their own hazardous waste such as needles, tissues, organs and other body parts, but the government has not provided a dumping site. Some hospitals burn in the open, and others use sub-optimal incinerators that releases dioxin and furans. Despite the government regulations, requiring every hospital to properly dispose of waste, authorities have failed to enforce it. There is a confusion among the implementing agencies as to who should take the lead role in the area.

¹³ Ibid

¹⁴ Water, sanitation and hygiene in health care facilities: status in low and middle income countries and way forward: WHO, 2015

¹⁵ Safe Water Reduce Child Death In Nepal: WaterAid Nepal: 2015

¹⁶ Fact-finding Survey of Nosocomial Infection Control in Hospitals in Kathmandu, Nepal—A Basis for Improvement: Hiroshi Ohara et al, 2013

¹⁷ Survey undertaken by the Central Bureau of Statistics in 2013

76. There are many successful projects being run in government hospital which, experts believe, can be replicated in various other hospitals as well. On July 20, 2010, Bir Hospital launched a medical waste management program which has since become an example for the country. The hospital administration, with support from Health Care Foundation-Nepal (HECAF), started the program to manage and dispose of hazardous medical waste that had long been finding its way into community landfills.

77. On the environmental aspects related to the health sector, these weaknesses and deficiencies have resulted in:

- a. insufficient legislation and regulatory framework;
- b. limited awareness of the health impacts of poor infection control and health care waste management practices
- c. lack of clarity on the roles/ responsibility of the organization/agencies for HCWM
- d. inadequate coordination and low priority among stakeholders; and
- e. weak implementation of existing policy, acts, regulations and guidelines.

78. Some pilot initiatives have been successfully implemented such as No-burn technologies and Zero-waste programs in some hospitals in Civil Service Hospital, Bhartapur Hospital, Bir Hospital and Gangalal Heart Hospital.

6.2 Potential Environmental Risks

79. The PforR focuses on improving health service delivery and strengthening fiduciary systems and as such is not expected to have adverse environmental impacts. However, **the Program provides an opportunity to improve and mainstream these issues within the systems strengthening objective of the PforR and also meet its overarching objective of improving health service delivery.** This opportunity is recognized by the GoN which has expressed interest and commitment to identify and address the **main environmental risks** associated with the health sector service delivery in Nepal. These are primarily related to:

- i) Risk of spread of infection through poorly managed healthcare waste, including (i) sharp waste (e.g., hypodermic needles, scalpels etc.); (ii) chemical waste (e.g., reagents, solvent etc.); pathological waste (e.g., human tissues, body parts, fetus, etc.); (iii) infectious waste (e.g., blood and body fluids etc.); (iv) pharmaceutical waste (e.g. outdated medications, etc.); and (v) waste with high heavy metal content (e.g., batteries, thermometers etc.). Unhygienic and unsanitary conditions at healthcare facilities can increase the risk and potential for patients to get Hospital Acquired Infections (HAI). The WHO estimates that 5 to 30 percent of patients globally develop avoidable nosocomial¹⁸ infections during their stay in health care facilities due to lack of proper sanitation and unhygienic environment¹⁹, such as HIV and hepatitis, gastroenteric, respiratory, and skin infections. Over 1.4 million people worldwide suffer from infectious complications acquired in hospital, and it is estimated that the highest frequencies of these -10% - were reported from hospitals in

¹⁸ Infections which are a result of treatment in a health care service unit but secondary to the patient's original condition; they appear 48 hours or more after hospital admission or within 30 days after discharge.

¹⁹ WHO fact file on sanitation, 10 facts on sanitation, March 20, 2008 (<http://www.who.int>).

South-East Asia Region.²⁰ Those most at risk include healthcare workers, staff, patients and also workers in waste disposal facilities (such as landfills or incinerators), scavengers and rag-pickers. Additional poor practices with regard to general (non-infectious) waste, such as inadequate storage, poor collection and untimely disposal can attract stray animals and rag pickers and become breeding grounds for vector- borne, water-based and fecal-oral infections.

- ii) Poor infection control and occupational health and safety practices due to (i) lack of usage of Personal Protective Equipment (PPE); (ii) re-use of contaminated/poorly recycled PPE and sharps; (iii) inaccurate source segregation of infectious waste resulting in accidents or needle-pricks; (iv) poor or deficient treatment of infectious consumables and waste; (v) lack and/or shortage of PPE and appropriate consumables and (vi) lack of training, awareness and understanding of health risks of such poor practices.
- iii) Contamination of water bodies through inadequate disposal of drug waste, expired pharmaceuticals, heavy metals such as mercury, phenols and disinfectants
- iv) Toxic emissions of dioxins and furans from slow burning of unsegregated waste (from incinerators and slow-burning pits), including plastics (syringes, tubing etc.) which are detrimental both to the neighboring community and also have regional and global environmental impacts.

6.3 Potential Environmental Benefits and Opportunities

80. Environmental management in the health sector is a public good with wide-ranging externalities. Good health and a clean environment reduce the disease burden and increase the economic productivity of individuals, and thereby has the potential for improving economic growth. Good environmental management for the health care sector includes efficient infection control measures, adequate and clean water supply and sanitation, occupational health and safety of staff, and proper disposal of infectious wastes and wastewater. It is important not simply for reduction of its environmental footprint but also for its direct impact on outcomes by reducing the risk of infection and preventing potential diseases through the provision of a clean, hygienic and safe environment for health workers and patients alike.

81. The PforR focuses on improving health service delivery and strengthening systems and the scope of the program is not expected to have significantly adverse environmental footprint. It, however, provides **an opportunity to enhance systems to ensure provision of safe, clean and hygienic health services while also providing an opportunity to improve measures for waste recycling and minimization.** Its broad environmental goals will be to:

- Create an infection-free and hygienic environment with good occupational health and safety practices
- Treat, disinfect and safely dispose infectious healthcare wastes and wastewater.
- Promote good practices such as waste recycling and minimization.
- Improve ease and safe accessibility

²⁰Nosocomial Bacterial Infection and Antimicrobial Resistant Pattern in a Tertiary Care Hospital in Nepal, Sah MK et al, 2014,

Social Risks and Opportunities of the Program

6.4 Data and Findings:

82. The gap between the poorest and the wealthiest has increased since 2001 for under-five mortality rates and in fact, the rate of 75 per 1,000 children for the poorest is double the rate of 36 per 1,000 for the wealthiest quintile.²¹ Likewise infant mortality rate of 69 and 65 for Muslims and Dalits respectively is significantly higher when compared with 45 for Brahmin Chhetri.²² Only 55.2 percent of births are in a health facility, and this proportion is only 27.9 percent among the poorest quintile.²³

83. Due to stock-outs and expiry of medicines, recipients of health services, including vulnerable groups, are unable to get quality services. According to an OAG survey, 72 percent of primary health centres, 69 percent of health posts, 87 percent of sub-health posts, and 50 percent of hospitals had experienced stock-outs of one or more essential drugs in 2012-13.²⁴ Likewise there is a deficit of qualified health workers, particularly in remote areas as a result of which the proportions of sanctioned posts that are filled by doctors and nurses at various levels of health facilities range from 23 to 55 percent.²⁵

84. The Service Tracking Survey (STS) in 2011 found that Brahmins and Chhetris (94%) were more likely to be aware of free health care than Tarai/Madhesi other castes (80%). More clients from the hill districts (54%) received free delivery care than those from mountain (26%) and Tarai districts (41%).²⁶

6.5 Potential Social Risks

85. The **major social risks** associated with the Program are primarily related to:

- i) Continued equity gap in health care services due to a number of barriers namely, financial, socio-cultural, geographical and institutional, resulting in wide variations across different population groups in terms of access to and availability of health services, utilization of health services, and their health status. While these are systemic problems that affect the health system broadly, the inability of the MoH to direct public resources to areas and

²¹ Ministry of Health & Population, New ERA and ICF International Inc., "Nepal Demographic and Health Survey 2011."

²² Ministry of Health & Population, New ERA and ICF International Inc., "Nepal Demographic and Health Survey 2011."

²³ 2014 Multiple Indicator Cluster Survey.

²⁴ OAG's Annual Reports of the Health Sector, 2010-14.

²⁵ Service Tracking Survey, 2012-2013

²⁶ Government of Nepal. "Existing situation of Gender Equality and Social Inclusion (GESI) in Health," in *Operational Guidelines for Gender Equality and Social Inclusion Mainstreaming in the Health Sector*, Ministry of Health and Population, 2013.

groups in need could perpetuate the existing inequities in the health services delivery. While DLI 9 focuses on reforms to improve planning and monitoring for evidence-based decision through the use of DHIS 2 to access disaggregated data by geography, gender and caste/ethnicity, the extent to which evidence-based decision making takes place depends on the institutional capacity of MoH, particularly, the DoHS to obtain information decentralized units and make investments accordingly.

- ii) Inadequate consultations and citizen engagement, including with vulnerable groups. The MoH's Gender Equality and Social Inclusion strategy includes measures to strengthen citizen engagement. Accordingly, different social audit approaches and guidelines have been developed by the Department of Health Services in 2009. Despite evidence indicating that these practices of social audits foster community ownership, raise community awareness about entitlements, and increase commitment and sensitivity of service providers, several implementation challenges remain. Lack of clear and intensive orientation on the principles, processes and tools of social audit; difficulties in compiling information gathered through the use of citizen score cards; absence of clear criteria for selecting facilitators for social audits; lack of uniformity in data collection and quality of discussions with stakeholders and communities; and lack of effective mechanisms for linking information from social audits to programming, including course correction.²⁷

- iii) Lack of Awareness. Despite the number of initiatives by the government to address some of the barriers to accessing health care services, including the introduction of the 'Free Health Care Programme' in 2008, there is only limited awareness about these services. While there are no direct risks related to increased health care costs from elements of the program, improving demand side accountability mechanisms is one of the major objectives of the program. There is a risk of elite capture in activities relating to citizen engagement and vulnerable groups not being aware of or engaged in the same. The inability to establish institutional systems and mechanisms for informing and making local communities aware of their rights, responsibilities and service provisions available to them would limit the effectiveness of improvements in public procurement and public financial management envisaged by the program.

6.6 Potential Social Benefits

86. The Program focuses on improving efficiency in public resource management systems of the health sector in Nepal, and the activities envisaged under the Program are not expected to have significantly adverse social impacts. The PforR is intended to help the Government and implementing agencies in overcoming deficiencies with regard to **equity outcomes, citizen engagement and systemic improvements**. Improved public financial management in the health sector linked with DLI 2 will reduce the existing inefficiencies in public expenditure planning and spending and also facilitate **better redistribution of resources** through more evidence-based resource allocation and better targeting linked to DLI 10. This will contribute towards ensuring that affordable and appropriate health services are available to all, particularly the disadvantaged and

²⁷Basu Dev Neupane. "A Review of Social Audit Guidelines and Practices in Nepal," September 2011.

vulnerable groups. The DLI 11 on Citizen Feedback mechanisms and systems for public reporting is particularly relevant from social development perspective

87. Specifically, one of the recurring problems in the health sector has been that drugs for reproductive health as well as family planning devices are often not available in time and in sufficient varieties for disadvantaged groups, despite the policy provisions (e.g., Ten Point Health Policy Program 2007, Free Health Service Program 2007/08, and the Three Year Plans formulated since 2011-2013)²⁸. Predictable availability of drugs and better targeting of public resources through DLI 4 and DLI 5, will benefit users of health facilities, including vulnerable groups. Through DLI 10, improved systems through DHIS 2 will enable regular capture, access and monitoring of data disaggregated by geography, gender, caste/ethnicity. Such information/data can be used for planning and evidence-based decision making, particularly for better targeting to improve access and equity to disadvantaged and vulnerable groups. Additionally, through DLI 11, **strengthened citizen engagement by improving the access of local citizens**, including vulnerable groups, to information and capturing their voice and feedback to gain feedback on availability of drugs and facility-level services will institutionalize demand-side governance, enhance accountability and ultimately lead to improved state responsiveness. **Improved accountability** will also help ensure that the service providers will “supply” services as agreed and thus ensure that affordable access to health services is provided and maintained.

²⁸ Government of Nepal. 2014. Health Management Information System: HMIS Indicators, 2070; Ministry of Health. 2009. “Health Sector Gender Equality and Social Inclusion Strategy”

SECTION V: OPERATIONAL PERFORMANCE AND INSTITUTIONAL CAPACITY ASSESSMENT

88. A SWOT (Strengths-Weaknesses-Opportunities-Threats) approach was used to analyze the six Core Principles outlined in the Operational Policy, based on a review of existing documentation, assessment of the environmental and social implementation performance and consultations with stakeholders, in the following manner:

- Strengths of the system, or where it functions effectively and efficiently and is consistent with the Operational Policy;
- Inconsistencies and gaps (“weaknesses”) between the principles advocated in the Operational Policy and capacity constraints
- Actions (“opportunities”) to strengthen the existing system.
- Risks (“threats”) to the proposed actions designed to strengthen the system.

89. The ESSA analysis focused on the Bank financed PforR, which carved out specific boundaries of intervention within a wider NHSS program. Since the specific actions of the PforR are focused on systems strengthening, the ESSA focused on strengthening the environmental and social management systems related to infection control and waste management which has a direct impact on reducing risk of infections and thereby improving health service delivery; Its focus on inclusion of vulnerable communities will have a direct impact on improved access to health services.

90. The summary of the applicable Core Principles and the Systems Assessment, based on the SWOT analysis, is provided below. The description of the Core Principles and the detailed SWOT analysis tables are provided in Annex II.

7.1 Summary of Systems Assessment

Core Principle 1: General Principle of Environmental and Social Management

Environmental and social management procedures and processes are designed to (a) promote environmental and social sustainability in Program design; (b) avoid, minimize or mitigate against adverse impacts; and (c) promote informed decision-making relating to a program’s environmental and social effects.

Summary Findings:

While considering the applicability of this Core Principle, the analysis found that it was relevant for the program in terms of improving infection control and waste management practices that have a direct impact on the objective of providing clean and safe health services. Discussions and consultations carried out as part of the ESSA analysis indicate a commitment, agreement and willingness by GON, donor partners and non-governmental agencies to address issues that are compromising the efficiency of health services and posing a threat to environmental. The current practices at most healthcare facilities are deficient and inadequate, with poor infection control and occupational health and safety practices, unsatisfactory infectious waste management, including treatment and disposal of infectious wastes posing a high risk of spread of infections and other infectious diseases. Pilot programs on good infection control practices, zero-waste initiatives and use of non-burn technologies have been successfully initiated and implemented, although not systematically replicated. HCWM Guidelines

prepared by MoH are being implemented, but in a piecemeal manner due to insufficient funds. However there has been no systematic implementation due to i) lack of a regulatory framework for infectious waste management; (ii) absence of a national coordinating institutional mechanism and strategy; (iii) narrow view of healthcare waste management rather than a cradle-to-grave view of infection control and waste management; (iv) insufficient and dedicated budget; and (v) lack of clarity of roles and responsibilities of various agencies involved in waste management. The draft HCWM Regulations and the existing HCWM Guidelines need revisiting and enhancement to include clarity on processes and responsibilities of different ministries and agencies.

Core Principle 3: Public and Worker Safety: Environmental and social management procedures and processes are designed to protect public and worker safety against the potential risks associated with (a) construction and/or operations of facilities or other operational practices developed or promoted under the program; (b) exposure to toxic chemicals, hazardous wastes, and otherwise dangerous materials; and (c) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards.

Summary Findings:

The Program will not support any civil works or large construction work although there are issues related to infection control and good operating practices by healthcare workers dealing with chemicals and risks from infectious diseases. However the provisions in Core Principle 3 are considered as part of the occupational health and safety issues related to chemicals usage and handling infectious waste as analysed under Core Principle 1.

Core Principle 5: Indigenous Peoples and Vulnerable Groups: Due consideration is given to cultural appropriateness of, and equitable access to, program benefits giving special attention to rights and interests of Indigenous Peoples and to the needs or concerns of vulnerable groups.

Summary Findings:

While considering the applicability of this Core Principle, the analysis found that this principle is relevant. There is a need to ensure that vulnerable and marginalized groups, including indigenous people, are included in the planning process (especially needs prioritization), implementation and monitoring of program activities; that vulnerable groups have access to program benefits; and that the needs of vulnerable groups are considered with respect to the Programs impacts. The ESSA analysis of vulnerable groups focused on those defined in the 'Operational Guidelines for GESI Mainstreaming in the Health Sector', namely, groups who have been systematically excluded over a long time due to economic, caste/ethnic, disability and geographic reasons (e.g., women, Dalits, indigenous people, Madhesis, Muslims, people with disabilities', senior citizens, sexual and gender minorities, and people living in remote regions), poor, unreached groups, and underserved areas. Findings indicate that the legal and policy framework as well as the political commitments to gender and social inclusion have laid down the foundation addressing gender and social exclusion issues in the health sector and integrating GESI into systems and services. A comprehensive institutional structure for GESI mainstreaming has also been established from the ministry level down to individual health facilities. However, there are a number of factors that impede effective health service delivery to vulnerable groups despite the fairly strong institutional and policy framework for mainstreaming GESI. These include: weak institutional capacity, including insufficient allocation of financial and human resources to reach vulnerable groups; shortage of skilled workers, drug stocks, ancillary health facilities, referral services, and other services required by vulnerable groups; centralized programming which undermines

localized management of resources according to the local priorities and needs; high opportunity cost (e.g., wage loss) while seeking care and high out of pocket expenditure; harmful cultural practices and stigma associated with particular services (e.g., family planning); inability of women to make independent decisions on matters related to their own health, especially sexual and reproductive health; inappropriate attitude and behavior of health service providers; and inconveniently located or distant health facilities.

7.2 Integrated Risk Assessment

91. Based on the analysis, the following table aggregates the risks assessed within the SWOT analysis and proposed measures to mitigate those risks, detailed in Section VI.

Risk Description	Risk Management
<p><i>Potential Environmental and Social Impacts</i> of Program are not identified and mitigated</p>	<p>The Program is not expected to have significantly adverse environmental footprint. The environmental risk associated with the program is low since it does not directly finance health service delivery. However, the Program provides an opportunity to improve systems to ensure provision of safe, clean and hygienic health services while also providing an opportunity to improve measures for infectious diseases control and health care waste management and minimization. The ESSA has developed a system strengthening measures matrix, in consultation with GoN and other stakeholders (donor partners, NGOs etc.), which focuses on strengthening the regulatory framework, enhancing institutional capacity, operationalizing implementation arrangements and improving technical capacity through better guidelines and standards. Monitoring and supervision of due diligence measures related to environmental and social issues will also be a part of World Bank implementation support.</p>
<p><i>Staffing, technical capacity and budgetary resources are insufficient</i> to handle environmental and social management issues. Poor record of implementation performance in environmental management and persistent discrimination or limitations of access to the system based on geography, ethnicity, caste etc.</p>	<p>The Program includes support for training and capacity building, while also requiring the institutionalizing of dedicated coordination units for monitoring and implementation of the ESSA activities; The program has a dedicated DLI for improved citizen engagement and outreach to vulnerable groups while also supporting the strengthening and mainstreaming of GoN’s GESI strategy.</p>

**SECTION VI: RECOMMENDED MEASURES TO STRENGTHEN
SYSTEMS PERFORMANCE**

8.1 System Performance Strengthening

92. The Program ESSA analysis presented above identifies strengths, gaps and opportunities in Nepal’s environmental and social management system with respect to effectively addressing the environmental and social risks associated with the Program. This section converts these gaps and opportunities into a viable strategy to strengthen environmental and social management capacity and performance at the national and local level. The analysis identified the following main areas for action in order to ensure that the Program interventions are aligned with the Core Principles 1, 3, and 5 of the Operational Policy for improved environmental and social due diligence.

Measures to Strengthen System Performance for Environmental and Social Management	
Objective	Measures
Systems for Environmental Management	<ul style="list-style-type: none"> • MoH to develop an Integrated Infection Control and HCWM Strategy by year 1 (including implementation plan and institutional responsibilities for coordination, implementation, monitoring and reporting). • Based on the strategy, MoH to liaise with MoPE for the review and revision of the existing HCWM Regulations which will (i) mandate institutional, implementation and enforcement responsibilities related to infection control and waste treatment and disposal; and (ii) annual budgetary allocations. This will be done in consultation with key stakeholders (e.g. government, private and NGO and donor agencies). • MoH will facilitate MoPE and ensure that the Regulations are submitted for consideration by Cabinet by year 1.5 of the Program. • GoN to approve revised HCWM regulations by year 3 of the Program.
Systems for mainstreaming GESI	<ul style="list-style-type: none"> • MoH to expand the scope of GESI and improve the Operational Guidelines to include issues of disability, mental disabilities, geriatrics and rehabilitation of GBV victims; and ensure inter-ministerial collaboration and coordination with civil societies and strengthen one-stop crisis centers.
Budgetary and Institutional mechanism	<ul style="list-style-type: none"> • DLI Management and Coordination Unit at MoH will be responsible for implementation of the ESSA action plan. (This could be done in collaboration with Management Division of DoHS and Curative Division of MoH). • MoH to discuss with MoF the requirement of a dedicated budget line with annual allocations within the MoH annual budget by year 3. A flexible funding mechanism for DHOs and DPHOs to respond to local health needs and disparities and formalize criteria and implementation guidance to ensure that the needs and priorities of women and poor and excluded people identified through the DHIS and citizen engagement are addressed.

<p>Technical Guidance and Implementation Capacity</p>	<ul style="list-style-type: none"> • MoH to revise HCWM Guidelines to standardize procedures, processes and implementation arrangements for infection control and waste treatment and disposal; demarcate roles and responsibilities of primary agencies including enforcement, multi-agency coordination and budgetary requirements (in parallel with revision of the Regulations) by year 2. The Guidelines should also include recommendations on waste treatment and disposal technologies, infrastructure and practices; use of personal protective equipment and occupational health and safety practices and supervision and reporting mechanisms. • MoH to develop and/or update existing guidelines and training modules and methodologies in line with the revised Regulations; Rolling out of training at central, regional, district and PHC levels by year 3. • MoH to develop strategy for strengthening capacity of institutions and health facilities for mainstreaming GESI in planning, budgeting, implementation and monitoring. This will include improving coordination and collaboration between different levels with other government sectors, external development partners and civil society. • MoH to provide support to gathering and analysis of evidence required for effective GESI planning, especially by utilizing information from the DHIS and citizen engagement procedures. • Continue consultations (with health staff and local community based organizations and NGOs working in the health sector, at divisional, central, district and regional levels) during the preparation of annual work plans and budgets to mainstream GESI activities. • Continue trainings to strengthen the skills of staff and focal points for mainstreaming GESI in planning, budgeting, implementation and monitoring (especially in terms of identification of barriers faced by vulnerable groups in accessing health services; disaggregation of data and delivering services in a GESI sensitive manner).
<p>Systems for Information Disclosure and Stakeholder Consultation</p>	<ul style="list-style-type: none"> • DLI 2, which focuses on establishing a Grievance Redressal Mechanism, will enable the provision of information on grievances received and addressed and thereby provide full disclosure and transparency. • DLI 11 will focus on developing and piloting citizen engagement mechanisms to gain feedback on availability of drugs and facility-level services In accordance with this DLI, MoH will develop and operationalize pilot citizen feedback mechanisms and systems for public reporting for different geographical contexts and adapted accordingly. • MoH will monitor and evaluate citizen engagement plans and improve district and central level responses. This will include a functional mechanism to ensure that findings from these citizen engagement mechanisms are used to improve accountability of service providers responsible for "supplying" services.

8.2 The Grievance/Complaint Redress Mechanism

93. Communities and individuals who believe that they are adversely affected by a World Bank supported project may submit complaints to existing project-level grievance redress mechanisms or the Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the World Bank's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond²⁹.

²⁹ For information on submitting complaints to the World Bank's corporate Grievance Redress Service (GRS), <http://www.worldbank.org/GRS>.
For information on submitting complaints to the World Bank Inspection Panel: www.inspectionpanel.org.

ANNEX I: DISBURSEMENT LINKED INDICATORS

<p><i>Results Area 1: Improved Public Procurement</i></p> <ul style="list-style-type: none"> • DLI 1: Percentage of contracts managed by the LMD through the PPMO’s onlie e-procurement portal. This DLI will focus on enhancing the capacity of the LMD to better manage procurement by incentivizing e-procurement. • DLI 2: Production and submission of Annual Report on grievances received and addressed through a web-based Grievance Redressal Mechanism. This DLI will focus on enhancing the capacity of the LMD to better manage procurement through the use of a Grievance Redressal Mechanism. • DLI 3: Percentage of procurements done by the LMD using standard specifications. This DLI will focus on creating greater transparency in the procurement of the basic package of drugs and equipment by establishing the use of standard specifications. • DLI 4: Percentage of district stores reporting based on a Logistics Management Information System (LMIS). This DLI will focus on supporting the revision of a LMIS and training personnel on its use to produce real-time web-based information for managing and reporting inventory of drugs. • DLI 5: Percentage reduction of stock-outs of tracer drugs in district stores. This DLI will reflect improvements in how the MoH uses the information available through the revised LMIS to better analyze stock-outs and create systems to manage stock inventory, thereby contributing to the timely availability of drugs to the population. • DLI 6: Percentage improvement in Effective Vaccine Management (EVM) score over 2014 baseline. This DLI focuses on improvements in the quality of pre-shipment, cold chain and warehouse management, stock management, and information systems for vaccines, serving as a marker for management of the entire cold chain.
<p><i>Results Area 2: Improved Financial Management</i></p> <ul style="list-style-type: none"> • DLI 7: Percentage of the MoH spending entities submitting annual plan and budget using Electronic Annual Work Program Budget (eAWPB). This DLI focuses on reforms that support better convergence and coordination in plan and budget preparation through an online planning and budgeting. This will result in less duplication and ultimately enable better prioritization and monitoring of a sector program. • DLI 8: Percentage of the MoH’s annual spending captured by TABUCS. This DLI will focus on reforms to improve internal budgetary control systems by incentivizing the use of an online expenditure reporting system by every MoH spending unit. This will result in better reporting, tracking, and monitoring of the use in the health sector and allow for evidence-based financial management. • DLI 9: Percentage of audited spending units responding to the OAG’s primary audit queries within 35 days. This DLI focuses on enhancing accountability through improving the internal control framework for financial management in the MoH. This will result in establishing institutional mechanisms for the tracking and responding to audit queries in a timely fashion by audited spending units.
<p><i>Results Area 3: Improved Reporting and Information Sharing for Enhanced Accountability and Transparency</i></p> <ul style="list-style-type: none"> • DLI 10: Percentage of districts which have all facilities reporting annual disaggregated data using DHIS 2. This DLI focuses on improvements in planning and monitoring for evidence-based decision making through the establishment and use of DHIS 2 to access data disaggregated by geography, gender, and ethnicity. This will contribute to better targeting to improve access and equity. • DLI 11: Operationalization of the citizen feedback mechanisms and systems for public reporting. This DLI will focus on developing and piloting citizen engagement mechanisms in different geographical contexts to gain feedback on availability of drugs and facility-level services to both institutionalize

demand-side monitoring and create better accountability.

ANNEX II: SWOT ANALYSIS AND SUMMARY OF FINDINGS

1. *Core Principle 1: General Principle of Environmental and Social Management*

Environmental and social management procedures and processes are designed to (a) promote environmental and social sustainability in Program design; (b) avoid, minimize or mitigate against adverse impacts; and (c) promote informed decision-making relating to a program’s environmental and social effects.

Program procedures will:

- Operate within an adequate legal and regulatory framework to guide environmental and social impact assessments at the program level.
- Incorporate recognized elements of environmental and social assessment good practice, including (a) early screening of potential effects; (b) consideration of strategic, technical, and site alternatives (including the “no action” alternative); (c) explicit assessment of potential induced, cumulative, and trans-boundary impacts; (d) identification of measures to mitigate adverse environmental or social impacts that cannot be otherwise avoided or minimized; (e) clear articulation of institutional responsibilities and resources to support implementation of plans; and (f) responsiveness and accountability through stakeholder consultation, timely dissemination of program information, and responsive grievance redress measures.

Applicability

Core Principle 1 is considered in terms of environmental and social management for the health sector, as a key component of good service delivery (i.e. measures included under the PforR’s system-strengthening measures for enhanced accountability and oversight mechanisms).

Strengths

Discussions and consultations carried out as part of the ESSA analysis indicate a commitment, agreement and willingness by Government of Nepal, donor partners and non-governmental agencies to address issues that are compromising the efficiency of health services and posing a threat to environmental and public health at large. There is a strong recognition of environmental sustainability and the desire for Program interventions to contribute towards reduced pollution and a better quality of life, as well as strengthened institutions.

There are HCWM guidelines in place, which have issued by MOH; Budgetary Guidelines for block grants include recommended allocation of budgetary amount for infectious diseases and HCWM.

HCWM guidelines approved by MoH has mentions the concept of Central Treatment Facility (CTF) in the guideline as one of the options for the proper HCWM.

Gaps

Lack of Regulatory framework

- The absence of dedicated regulations for infection control and health care waste management has resulted in a fragmented approach
- The HCWM guidelines are being implemented in a piecemeal manner due to lack of grounding within a defined regulatory framework and without clearly defined roles and responsibilities of the various agencies and stakeholders
- The draft HCWM Regulations and the existing HCWM Guidelines do not comprehensively address issues related to infection control, good practices and infectious waste management treatment and disposal

Operational Practices:

- Poor practices related to infection control and management of healthcare waste, including inadequate segregation, and unmethodical methods of collection and disposal. Although there are some healthcare facilities which are implementing good practices in waste disposal, most resort to treatment and dumping in municipal waste stream or else burning the infectious waste in the backyards.
- Insufficient training and awareness of healthcare staff and workers with regard to occupational safety and infectious waste management practices.

<p>GON has initiated the procurement of non-mercury based equipment and has rolled out the use of disposable and AD syringes for immunization programs.</p> <p>Pilot programs on good infection control practices, zero-waste initiatives and use of non-burn technologies have been successfully initiated and implemented.</p>	<ul style="list-style-type: none"> • Insufficient waste management equipment and poor and inaccurate utilization; lack of standardized disposal facilities; poorly operated incinerators and overuse of burning pits; Shortage of fundamental equipment including PPE, inadequate practice of basic techniques such as standard precautions, inappropriate use of surveillance results, improper disinfection and sterilization methods. • While social media and communities have raised issues and concerns related to poor waste management practices, public pressure and community involvement for improved governance and accountability could be enhanced. There is low awareness regarding nosocomial infection control and insufficient information dissemination on risks and benefits of good ICWM. <p><i>Weak Institutional capacity and mechanism</i></p> <ul style="list-style-type: none"> • Weak institutional capacity to address environmental issues related to health sector, especially infectious waste. • Lack of clarity on roles and responsibilities for ICWM, inspection, monitoring and enforcement which results in poor accountability and quality control. • Seemingly weak inter-institutional mechanisms and coordination between relevant agencies; differing and/or overlapping mandates. • Healthcare facilities do not have HCWM Committees, standard operating procedure, and proper color coding systems. • No attention is given to wastewater treatment. • Although MOH has rolled out some training sessions at certain healthcare facility levels, this is insufficient and not replicated or followed-up. • Some good practices have been implemented but not replicated or scaled up. <p><i>Resources – Human and Financial</i></p> <ul style="list-style-type: none"> • Lack of resources to establish streamlined systems for ICWM and procure Personal Protective Equipment and required technologies. • Lack of a dedicated unit within MoH to provide overarching strategy and coordination. • The Management Department of MoH, which has been implementing some training, is severely under-
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	<p>resourced (manpower and funds).</p> <ul style="list-style-type: none"> • Inadequate staffing of qualified infection control and HCWM specialists at national and district levels and weak ICC function³⁰, • Poor monitoring and database management of healthcare facilities, both public and private. • Lack of systematic and dedicated budgetary allocation for ICWM within the central MoH.
<p>Actions and Opportunities</p> <ul style="list-style-type: none"> • There is opportunity to institute long-term structural changes to strengthen infection control and waste management practices and systems in Nepal to support improved health service delivery and reduce potential of environmental damage and public health risk including implementation capacity for monitoring, evaluation and reporting, along with public participation and disclosure. • Empowering and clearly demarcating the roles and responsibilities of agencies such as MoPE, MOUD, MoFALD, KMC and SWMTSC. • Strengthening cooperation and inter-sectoral coordination on ICWM between government agencies, private healthcare providers and associations, donor partners and other stakeholders. • Promotion of privately-owned centralized treatment and disposal facilities appears an attractive option in urban areas such as Kathmandu, as it could be more systematic and organized and also increase accountability for quality control in managing wastes. • There is an opportunity to replicate and up-scale existing zero-waste initiatives and no-burn technologies. 	<p>Risks</p> <ul style="list-style-type: none"> • Weak institutional capacity, including insufficient allocation of financial and human resources could prevent improvement of clean and safe health service delivery; and could result in unacceptable health and performance indicators. • Constant changes in staffing or changes in ministry portfolios could reduce the impact of change.

³⁰This is systemic problem in Health sector in Nepal which has a deficit of qualified health workers, particularly in remote areas as a result of which the proportions of sanctioned posts that are filled by doctors and nurses at various levels of health facilities range from 23 to 55 percent.

Core Principle 2: Natural Habitats and Physical Cultural Resources

Environmental and social management procedures and processes are designed to avoid, minimize and mitigate against adverse effects on natural habitats and physical cultural resources resulting from program.

As relevant, the program to be supported:

- Includes appropriate measures for early identification and screening of potentially important biodiversity and cultural resource areas.
- Supports and promotes the conservation, maintenance, and rehabilitation of natural habitats; avoids the significant conversion or degradation of critical natural habitats, and if avoiding the significant conversion of natural habitats is not technically feasible, includes measures to mitigate or offset impacts or program activities.
- Takes into account potential adverse effects on physical cultural property and, as warranted, provides adequate measures to avoid, minimize, or mitigate such effects.

Not applicable. The Program will not support any activities such as civil works that will require land acquisition. In the absence of any civil works, the risk of impacts on loss of land/asset/ formal and informal livelihood etc., from land acquisition are not likely. Based on experience in similar health projects there has been no relocation or other related impacts. Similarly, loss of access to natural resources is also a low risk. This principle therefore does not apply to the Program as no land will be acquired and there will be no economic or physical displacement.

Core Principle 3: Public and Worker Safety

Environmental and social management procedures and processes are designed to protect public and worker safety against the potential risks associated with (a) construction and/or operations of facilities or other operational practices developed or promoted under the program; (b) exposure to toxic chemicals, hazardous wastes, and otherwise dangerous materials; and (c) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards.

- 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.
- Promotes use of recognized good practice in the production, management, storage, transport, and disposal of hazardous materials generated through program construction or operations; and promotes use of integrated pest management practices to manage or reduce pests or disease vectors; and provides training for workers involved in the production, procurement, storage, transport, use, and disposal of hazardous chemicals in accordance with international guidelines and conventions.
- 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.

Applicability:

The Program has issues related to infection control and good operating practices by healthcare workers dealing with chemicals and risks from infectious diseases. However the provisions in Core Principle 3 are considered as part of the occupational health and safety issues related to chemicals usage and handling infectious waste as analysed under Core Principle 1.

Core Principle 4: Land Acquisition

Land acquisition and loss of access to natural resources are managed in a way that avoids or minimizes displacement, and affected people are assisted in improving, or at least restoring, their livelihoods and living standards.

As relevant, the program to be supported:

- Avoids or minimizes land acquisition and related adverse impacts;
- Identifies and addresses economic and social impacts caused by land acquisition or loss of access to natural resources, including those affecting people who may lack full legal rights to assets or resources they use or occupy;
- Provides compensation sufficient to purchase replacement assets of equivalent value and to meet any necessary transitional expenses, paid prior to taking of land or restricting access;
- Provides supplemental livelihood improvement or restoration measures if taking of land causes loss of income-generating opportunity (e.g., loss of crop production or employment); and
- Restores or replaces public infrastructure and community services that may be adversely affected.

Not applicable. The Program will not support any activities such as civil works that will require land acquisition. In the absence of any civil works, the risk of impacts on loss of land/asset/formal and informal livelihood etc., from land acquisition are not likely. Based on experience in similar health projects there has been no relocation or other related impacts. Similarly, loss of access to natural resources is also a low risk. This principle therefore does not apply to the Program as no land will be acquired and there will be no economic or physical displacement.

Core Principle 5: Indigenous Peoples and Vulnerable Groups

Due consideration is given to cultural appropriateness of, and equitable access to, program benefits giving special attention to rights and interests of Indigenous Peoples and to the needs or concerns of vulnerable groups.

- Undertakes free, prior, and informed consultations if Indigenous Peoples are potentially affected (positively or negatively) to determine whether there is broad community support for the program.
- Ensures that Indigenous Peoples can participate in devising opportunities to benefit from exploitation of customary resources or indigenous knowledge, the latter (indigenous knowledge) to include the consent of the Indigenous Peoples.
- Gives 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.

While considering the applicability of this Core Principle, the analysis found that this principle is relevant. There is a need to ensure that vulnerable and marginalized groups, including indigenous people, are included in the planning process (especially needs prioritization), implementation and monitoring of program activities; that vulnerable groups have access to program benefits; and that the needs of vulnerable groups are considered with respect to the Programs impacts. The ESSA analysis of vulnerable groups focused on those defined in the 'Operational Guidelines for GESI Mainstreaming in the Health Sector', namely, groups who have been systematically excluded over a long time due to economic, caste/ethnic, disability and geographic reasons (e.g., women, Dalits, indigenous people, Madhesis, Muslims, people with disabilities', senior citizens, sexual and gender minorities, and people living in remote regions), poor, unreached groups, and underserved areas. Findings indicate that the legal and policy framework as well as the political commitments to gender and social

inclusion have laid down the foundation addressing gender and social exclusion issues in the health sector and integrating GESI into systems and services. A comprehensive institutional structure for GESI mainstreaming has also been established from the ministry level down to individual health facilities. However, weak institutional capacity, including insufficient allocation of financial and human resources to reach vulnerable groups; incipient stages of GESI mainstreaming; shortage of skilled workers, drug stocks, ancillary health facilities, referral services, and other services required by vulnerable groups; centralized programming which undermines localized management of resources according to the local priorities and needs; high opportunity cost (e.g., wage loss) while seeking care and high out of pocket expenditure; harmful cultural practices and stigma associated with particular services (e.g., family planning); inability of women to make independent decisions on matters related to their own health, especially sexual and reproductive health; inappropriate attitude and behavior of health service providers; inconveniently located or distant health facilities, are some of the factors that impede effective health service delivery to vulnerable groups despite the fairly strong institutional and policy framework for mainstreaming GESI.

<ul style="list-style-type: none"> • The Government’s approach is to ensure that all vulnerable groups are consulted and benefit from Government programs. • The MoH's GESI strategy includes measures to strengthen citizen engagement. • The legal and policy framework as well as the political commitments to gender and social inclusion have laid down the foundation addressing gender and social exclusion issues in the health sector and integrating GESI into systems and services. • A comprehensive institutional structure for GESI mainstreaming has been established from the ministry level down to individual health facilities. • The business plan format now has a separate section for GESI-related activities. • Existing guidelines from the Management Division specify the procedures for RHDs to carry out annual and quarterly reviews and planning meetings. • GESI operational guidelines have been prepared to support the implementation of MoH's GESI strategy and GESI have been 	<ul style="list-style-type: none"> • Lack of budget for TWGs at all levels results in lack of interest in taking decisions and formulating plans and activities for supporting GESI-related activities, further undermining equity and access to essential services. • Weak institutional capacity, including insufficient allocation of financial and human resources to reach vulnerable groups; TWGs at the district do not have adequate technical assistance and the RHDs do not have the capacity and mechanisms for providing adequate support. • Shortage of skilled workers, drug stocks, ancillary health facilities, referral services, and other services required by vulnerable groups (e.g., rehabilitation services for victims of GBV). • Recipients of health services, including vulnerable groups, are unable to get quality services due to stock-outs and expiry of medicines. • Centralized programming undermines localized management of resources according to the local priorities and needs vis-à-vis GESI issues. Sector budget formulation processes are ad-hoc and largely uninformed by information from decentralized units where service delivery occurs. <p>GESI³¹</p> <ul style="list-style-type: none"> • High opportunity cost (e.g., wage loss) while seeking care and high out of pocket expenditure • Harmful cultural practices and non-acceptance/
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³¹ Source: Adapted from Government of Nepal, “Nepal Health Sector Strategy, 2015-2020,” Ministry of Health, 2015

<p>integrated into health sector business plans and annual work plans and budgets</p> <ul style="list-style-type: none"> • Issues of GESI have been well-integrated into the institutional systems that drive the health sector. 	<p>social stigma associated with particular services (e.g., family planning).</p> <ul style="list-style-type: none"> • Inability of women to make independent decisions on matters related to their own health, especially sexual and reproductive health • Inappropriate attitude and behavior of health service providers. • Inconveniently located or distant health facilities and difficult terrain restricting easy access; this is aggravated by seasonal problems such as floods, landslides which restrict movement and limited and inconvenient opening hours of health facilities.
<ul style="list-style-type: none"> • Improved skills of focal staff in identification of barriers that vulnerable groups face in accessing health services will support responsive planning, programming and budgeting and delivering services in a GESI sensitive manner. • Budgetary allocation and systematic and mainstreamed implementation will ensure that the needs and priorities of women and poor and excluded people and citizen engagement are addressed. 	<ul style="list-style-type: none"> • Weak institutional capacity, including insufficient allocation of financial and human resources to reach vulnerable groups could slow down movement towards universal health coverage. • GESI mainstreaming is still at initial stages and there are risks that if the current momentum is not sustained then the goals of equitable access to quality health services would be compromised.

Core Principle 6: Social Conflict

<p>Avoid exacerbating social conflict, especially in fragile states, post-conflict areas, or areas subject to territorial disputes.</p>
<p>Considers conflict risks, including distributional equity and cultural sensitivities.</p>
<p>Not Applicable: The Program will not entail social conflict in fragile states, post-conflict areas or areas subject to territorial disputes. However, the Program seeks to address issues of distributional equity thus risking social conflicts between groups that have captured health-care resources thus far and vulnerable groups who have been marginalized from accessing health care services. In this regard, the ESSA did not consider the Program with regards to Core Principle 6 but issues of distributional equity and cultural sensitivities are covered under the analysis of system with respect to the main considerations of Core Principle 5.</p>

ANNEX III: STAKEHOLDERS CONSULTATION

The ESSA process includes extensive stakeholder consultations and disclosure of the ESSA Report following the guidelines of the World Bank’s Access to Information Policy. At present, the ESSA consultation process is embedded in the Program consultation process. Feedback from stakeholders has been instrumental in designing and revising the Program Action Plan, indicators, and technical manual. Informal discussions were held with key stakeholders - MoPE, MoH, KMC, MoFALD during field visits; whose names are detailed in table below:

Persons met	Organization
1. Mr. Mahendra Shrestha, Joint Secretary	MoH
2. Dr. Bhim Acharya	MoH
3. Ms. Srijana Shrestha, Section officer	DoHs, MoH
4. Mr. Vishwa Mani Gyawali, Executive Director	SWMTSC, MoFALD
5. Mr. Dipendra Bahadur Oli, Legal Officer	SWMTSC, MoFALD
6. Mr. Rabin Man Shrestha, Chief, Environmental Division	KMC
7. Ms. Nisha Koirala, Environmental Engineer	KMC
8. Mr. Purthottam Nepal, Under Secretary	MoPE, Law and Judgement Verdict Sector

Consultation Event:

A public consultation was held on July 29, 2016 where the ESSA was presented and stakeholders were invited to offer inputs on the findings and recommended actions in an interactive format. The main supporting DPs for the health sector - WHO, KfW, UNFPA and USAID and representatives from the line ministries, NGOs working for the health sector participated in the meeting. The issues discussed are detailed in table below. List of participants is attached further below:

Issues Raised	Response
Infection Control and HCW is a critical issue which needs to be immediately addressed	Agreed
The needs for enactment of regulations for infection control and HCWM	All the invited participants agreed on the needs for enactment of regulations for HCWM
The program can be used as an opportunity to address the issue related with infection control and HCWM.	Agreed, Program interventions can contribute in infection control and waste management practices, strengthen the system and the relevant institutions and reduce potential of environmental damage and public health risk.
Lack of clarity on the responsibilities for managing HCWM.	There should be a designated agency/ coordination unit/ministry responsible for managing the waste.
Federalism structure to be considered while considering the designated agency/ministry	Agreed

for HCWM.	
There are many good practices being implemented in Kathmandu valley. These should be replicated.	Agreed; a national strategy for the ICWM must incorporate existing good practices and learn lessons for scaling up and replication.
Routine budget allocations for addressing the infection control and HCWM required.	Block budget is allocated but continuation needs to be given (budget to be provided item wise). Without budget there will be no implementation.
Dedicated unit/section within the MOH is essential for addressing the issue with regard to infection control and HCWM. Trained human resource required.	Agreed, and in addition capacity needs to be built.
What happens to the HCW beyond the facility? Will centralized treatment facility be able to address the problem?	Central facility will be able to address the HCW disposal issues. This type of facility will cater to smaller health facilities, clinics and pharmacy. But issues related to geographical location, land ownership, costing and pricing of services etc. need to be discussed with all key and affected stakeholders before a decision is made with regard to centralization of waste treatment and disposal.

List of participants who attended the consultation event:

NEPAL HEALTH SECTOR SUPPORT

Attendance List, July 29, 2016

S.No.	Name	Position	Organization	Tel/Fax No.	Email Address	Signature
1	Daniel Verschneider	MNCH Team Leader	USAID	98010 06902	dverschneider@usaid.gov	
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3	Andrea Soares	TO (SDG)	WHO	980 1010057	soaresa@who.int	
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5	Sitaram Poudyal	GESI Advisor	NHSSP	9843789117	sitaram@nhssp.org.np	
6	Anne Anstey	Team Leader	NHSSP	9851224301	anstey@nhssp.org.np	
7	Saru Bajendani	Env. Specialist	WB	9851033933	sbajendani@worldbank.org	
8	RUMA TAUBRATIT	" "	"		rtaubratit@worldbank.org	
9	DR. NARESH PRATAP KC	Director	Management Division DHS	9857042824	npratap@hmt.moh.gov.np	
10	Bandita Bajapati	Social Specialist	WB		bbajapati@worldbank.org	

NEPAL HEALTH SECTOR SUPPORT

Attendance List, July 29, 2016

S.No.	Name	Position	Organization	Tel/Fax No.	Email Address	Signature
1	Jaya Karli		WB		jkarki@worldbank.org	
2	Latika Maskey Pradhan	Asst. Rep	UNFPA	-	maskeypradhan@unfpa.org	
3	GIULIA VALLESE	REPRESENTATIVE	UNFPA	-	vallese@unfpa.org	
4	Manav Bhattarai	Health Specialist	WB		mbhattarai@worldbank.org	
5	Purushottam Nepal	Under Secretary (Law)	Ministry of Population & Environment	9841538999	mepalpurushottam@yamaali.com	
6	Mahesh Nakarmi	Director	HECAF	9851025549	mahesh.nakarmi@gmail.com	
7	Rishi Koirala	Env. Engineer	Katmandu Municipality			
8						
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ANNEX IV: METHODOLOGY AND REFERENCES

The following process steps were undertaken to prepare the ESSA:

- Preliminary review and screening of potential risks and impacts of the program.
- Desk review of the regulatory frameworks and guidelines and identification of inconsistencies or gaps with the social and environmental elements of the Bank Policy.
- Desk review of implementation experience of previous World Bank funded projects in the health sector.
- Review of existing reports (GoN, World Bank and donors).
- Assessment of the institutional roles, responsibilities and coordination mechanisms.
- Analysis of existing resources within Government (technical, manpower and financial) and commitment for implementation.
- Discussions and workshops with Government agencies, Development Partners, NGOs, professional Associations and other stakeholders.

In addition to the laws, policies, and regulations cited in this report, the ESSA has drawn from a range of sources including academic journals, Government documents, technical reports, evaluations, and project documents. This annex lists some of key documents and sources that were consulted in the preparation of the ESSA.

1. Impact of Citizen Charter in Service Delivery: A Case of District Administration Office, Kathmandu
2. Final Report on Hazardous Waste Policy Study Environment Division; Ministry of Environment Submitted by Amar B. Manandhar August 2010
3. Biomedical waste management in Nepal : A review – Choudhary et al: Journal of Universal College of Medical Sciences 2014
4. Nosocomial Bacterial Infection and Antimicrobial Resistant Pattern in a Tertiary Care Hospital in Nepal, Sah MK et al, 2014,
5. Fact-finding Survey of Nosocomial Infection Control in Hospitals in Kathmandu, Nepal—A Basis for Improvement: Hiroshi Ohara et al, 2013
6. Overview of Gender Equality and Social Inclusion in Nepal: Asian Development Bank, 2010
7. Impact of intervention on healthcare waste management practices in a tertiary care governmental hospital of Nepal: B. Sapkota et al, 2014
8. Meeting the Fundamental Need for Water, Sanitation and Hygiene Services in Health Care Facilities: WHO and UNICEF; 2014
9. Water, sanitation and hygiene in health care facilities: status in low and middle income countries and way forward: WHO; 2015