Lessons from the field: progress towards the sustainable development goals in Nepal in federal transition of the state

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INTRODUCTION

In Nepal, despite the decade-long internal conflict and unstable governments during the Millennium Development Goal (MDG) period, the progress in reducing maternal and child deaths has been praiseworthy. The under-five mortality reduced from 146 per 1000 live births to 42 per 1000 live births, and the maternal mortality ratio reduced by more than half between 1990 and 2015.[1] More than 85% of the children were fully vaccinated as per national schedule in 2015.[2] However, the progress was not uniform and disparities were considerable across different social, economic and geographical population groups. A large inequity gap was witnessed in skilled attendance at birth between the wealthiest and poorest families in 2016[2] (figure 1). The coverage of skilled attendance at birth was more than 90% among the women from the wealthiest families, but less than 40% among the women from the poorest families. Similarly, the wealthiest families have achieved neonatal mortality rate target for SDG, 12 per 1000 live births in 2017, while the poorest families will take an estimated further 40 years to achieve it.[1]

Nepal has been long recognised for community networks, which have led to the improvement in the social sector, such as forestry, education and health. In the health sector, mothers' groups facilitated by Female Community Health Volunteers have been able to bring change in the behaviour and household practice for maternal and newborn care using the community action cycle.[3]

The Sustainable Development Goals (SDGs) encompass a bigger range of global health issues than the MDGs and intersects with equality, gender, poverty and environment. The government of Nepal has committed to the SDGs and has developed the country SDG roadmap and accountability framework for 2016–2030.[4] The commencement of SDG period coincides with a major politicoadministrative transformation in Nepal. The 2015 Constitution of Nepal introduced federalisation and thus restructuring the unitary and centralised mode of governance to multilevel governments. In this paper, we examined the transition in the last few years and progress in health and well-being related SDG broadly (SDG3).

POLICY ENVIRONMENT

The 2015 Constitution enshrined health as a fundamental right.[5] As per the constitution, providing basic health services (BHSs) free of cost is the responsibility of the state.[5] BHS entails prevention and management of non-communicable diseases, in addition to the reproductive, maternal, newborn and child health and infectious diseases covering the broad spectrum that SDG3 entails. This sets a solid foundation for universal coverage of BHS essential for achieving SDG 3.

HEALTH SYSTEM PERFORMANCE

With the drive to prioritise non-communicable disease and environmental health in the SDG era, the government of Nepal has increased the policy attention and resource allocation in its annual plans and budget. A costed multisectoral plan for non-communicable disease has been developed and is being implemented. To improve the alliance for better evidence for environmental health and climate change, implementation research is being rolled out for informed decision-making. To ensure the continual MDG momentum for maternal, newborn and child health, increased allocation of the budget has been made for improving sick newborn care as per the Nepal's Every Newborn Action Plan 2016–2030.[1]

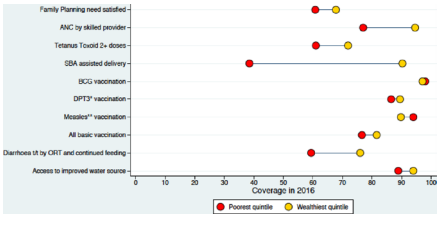

Figure 1 Coverage of reproductive, maternal, neonatal and child health intervention between poorest and wealthiest quintiles in 2016. ANC, antenatal care; BCG, Bacillus Calmette–Guérin; DPT3, third dose of diphtheria, pertussis and tetanus; ORT, oral rehydration therapy; SBA, skilled birth attendance.

COUNTRY HEALTH GOVERNANCE

With federalism, Nepal now has one federal, seven provinces and 753 local governments (293 urban and 460 rural municipalities).[5] Each level is autonomous by constitutional mandate and has the authority to develop its own laws, by-laws, policies and plans and generate revenue to implement them. Majority of the service delivery, including BHS, have been devolved as their exclusive rights and function to the local governments with fiscal and administrative authority for development. This takes the prioritisation and policy-makng and decision-making closer to the people with increased likelihood of interlinked development actions by multiple sectors. The decentralised governments are more accountable and responsive to people's needs and demands. These opportunities are however marred by teething problems of the transition.[5] The federal government has been slow in promulgating the laws and legal instruments to enable an effective federal transition. The local governments require additional support from the federal government to plan, budget, manage and monitor health programmes.

SERVICE DELIVERY

There is a wave of optimism among the local government representatives to tackle the existing gaps to provide more equitable healthcare services to the respective constituencies.[5] The local governments have reasonable infrastructure and technical capacity from the erstwhile centrally managed and firmly institutionalised district health system. Local health service delivery is still largely the continuation of health programme implemented through the centralised health system. The federal transition presents an unprecedented opportunity to reorganise and boost health service delivery. However, a

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protracted civil service adjustment to relocate the health worker to local and provincial health facilities remains a challenge. The delay from the local government to recruit health workers has led to shortages of health workers. Local government is responsible for procuring essential medicines and supplies. Lack of management skills and storage and distribution capacity at the local level have rendered supply chain management weak and fragmented.[1] The well-functioning maternal and child health programme, which depends on skilled human resource and commodity to deliver service, has faced challenges. There have been local government initiatives to coordinate with central ministry of health to resolve the problem and build its capacity.

CONCLUSIONS

It might be early to witness the impact of federal transition on health outcomes and SDG targets. With the politicoadministrative reform to reorganise the health system is an early sign to progress towards SDG goals. The acceleration towards SDG goals require settling the transitioning of health governance. Poor transitioning of skilled human resource and health supply chain management might halt the progress and loom into a catastrophic outcome. The evidence-based planning using the SDG principle of leaving no one behind at local level will improve universal healthcare for achieving health goals. The role of federal government will be critical to build capacity of the newly formed local governments on evidence-based planning and execution. Nepal stands at a crossroad to set a case story on SDG implementation to the global health audience.

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REFERENCES

1 Kc A, Jha AK, Shrestha MP, *et al*. Trends for neonatal deaths in Nepal (2001–2016) to project progress towards the SDG target in 2030, and risk factor analyses to focus action. *Matern Child Health J* 2019;59.
2 Thapa J, Budhathoki SS, Gurung R, *et al*. Equity and coverage in the continuum of reproductive, maternal, newborn and child health services in Nepal-Projecting the estimates on death averted using the list tool. *Matern Child Health J* 2019;379. doi:10.1007/s10995-019-02828-y. [Epub ahead of print: 30 Nov 2019].
3 Kc NP, Kc A, Sharma N, *et al*. Community participation and mobilization in community-based maternal, newborn and child health programmes in Nepal. *J Nepal Health Res Counc* 2011;9:101–6.
4 National Planning Commission GoN. *Nepal sustainable development goals: status and roadmap 2016-2030*. Kathmandu: National Planning Commission GoN, 2016.
5 Bhandari A, Pokharel S, Paudel P, *et al*. *Situational and political economy analysis report in Nepal*. Kathmandu: Asia Foundation and Public Policy Pathsala, 2019.