

COUNTRY HEALTH PROFILE

NEPAL



The boundaries shown on the above map do not imply official endorsement or acceptance by the World Health Organization.

SECTION 1: TRENDS IN POLICY DEVELOPMENT

A National Health Policy (NHP) in Nepal was formulated in 1991 with the objective of enhancing the health status of the population, 86% of which is rural. The NHP is a comprehensive policy that addresses service delivery as well as the administrative structure of the health system. The 8th Health Plan (1992-1997), 9th Health Plan (1997-2002) and Second Long Term Health Plan (SLTHP) (1997-2017) were developed in keeping with the NHP. The main features of the health plan were the development of integrated and essential health care services at the district level and below, active community participation and mobilization of the private sector to develop general as well as specialized health services, ensuring quality assurance in health care making MCH/FP an integral part of PHC services, Inter and Intra sectoral coordination, decentralization of health administration developing the traditional system of medicine, and promoting the participation of national and international NGOs, private enterprises and foreign investors. In practical terms, achievements include the adoption of an integrated approach to all programmes, and the implementation of special programmes such as district health systems development, safe motherhood, community drug schemes, the health management information system, and special surveys to re-evaluate the achievements in the implementation of the health policy. The main constraints are frequent changes of government, limited national resources for health services development, centralized administration, ineffective management and supervision, difficult geographic conditions and slow economic growth.

SECTION 2: TRENDS IN SOCIOECONOMIC DEVELOPMENT

2.1 Economic trends

The GDP per capita increased from US \$149 in 1992/93 to US \$224 in 1995/96. The annual growth rate of the GDP increased from 3.29% in 1992/93 to 4.90% in 1995/96. The proportion of the population living below the poverty line in 1988/89 was 40% (National Planning Commission), although other estimates cite higher levels, e.g. 71% (World Bank) and 66% (UNDP). During the last decade the general economic trend was not very encouraging. The increasing demand for development activities has led to difficulties in distribution of the government budget. This has been compounded by the conflict situation emanating from unsolved social problems. This in turn has necessitated the mobilization of external and internal loans to bridge the resource gap in each succeeding fiscal year. There is also a wide gap in development between urban and rural sectors, although 86% of the population live and work in rural areas, with the majority living below the poverty level. Eighty per cent (80%) of the total national income is concentrated in 10% of the households (Rastra Bank Survey 1988/89). Gender disparities also severely limit the full participation of women in development. Future plans include economic liberalization as a major strategy, employment promotion programmes with skill training, etc., area specific programmes targeted at low income population groups/families, more decentralization, and tighter fiscal policies.

2.2 Demographic trends

According to the national census conducted in 2001, the population of Nepal was 23,214,681. The annual population growth rate is 2.27 % and the total fertility rate (TFR) 4.1

(2001/2002). The crude birth rate (CBR) is 33.58 per 1000 population and crude death rate (CDR) 9.96 (2001/2002). With high fertility and gradually declining mortality, the population will remain young for many years to come and will also continue to grow, with consequences for various sectors, including the health sector. The urban population is estimated at 14.20 %, but there is an increasing trend of rural to urban migration as well as from hill to terai (plains) migration. Nepalese have been found to seasonally migrate to India and vice versa with easy passage of diseases and illegal trafficking across borders.

2.3 Social trends

The adult literacy rate for males (15 years and over) is 65.08 % and for females 42.49% (2001). Progress in the field of education is encouraging, with increasing school enrolment rates. Development and expansion of the communication media has also helped to generate health awareness. Health education has been included in school curricula and in non-formal adult education programmes.

A multisectoral approach has been adopted in the formulation of programmes such as safe motherhood, control of STD/AIDS, human resource development, etc. Programmes for women's development, poverty alleviation and more effective decentralization are also under implementation. The major constraints are difficulties in enhancing literacy among the female and rural populations, conservative social customs and traditions, the topography of the country, and centralized planning and administration with ineffective coordination and implementation. A 20-year long-term perspective health plan has been formulated with the objective of ensuring universal primary health care by the year 2017.

2.4 Food supply and nutritional status

The situation relative to protein-energy malnutrition does not seem to have undergone any significant change since the early 90s. The prevalence of underweight (weight-for-age) in children under 5 years was 47.1% and that of stunting 54.1% in 1998. Hospital data for 1993, the only available source of data for birth weights representing less than 1% of total births, reveal that 23.2% of newborns weigh less than 2500 grams at birth. A study conducted in 1994 among women of reproductive age reported a level of anemia of 63%. Other nutritional problems are iodine deficiency, which appears to have declined following universal iodization of salt and lipiodol supplementation in endemic areas, and vitamin A deficiency which has significantly decreased due to biannual mass supplementation with vitamin A capsules in endemic areas. The main constraints for improving nutritional status are poor accessibility of service provision, lack of community participation in growth monitoring activities, shortage of trained health personnel, lack of legal provisions for monitoring and control of iodization of salt, weak targeting, and poor compliance with iron supplementation. More efforts need to be directed at intersectoral collaboration, better monitoring and community mobilization.

2.5 Lifestyle

An epidemiological study among the rural community in the hilly region revealed that 85.4% of males aged 15 and over and 62.4% of females were regular smokers. Overall prevalence of tobacco use in the country is 38.4% (2000/2001) with 48.4% in males and 28.7% in females. Diseases related to lifestyles are on the increase, particularly those due to

smoking and alcohol and drug abuse. Efforts are underway to create greater public awareness of these problems with private sector participation. The main constraints are low literacy, poverty, cultural beliefs, lack of trained manpower, poor media promotion and limited resources.

SECTION 3: HEALTH AND DEVELOPMENT

3.1 General protection of the environment

Nepal's environmental challenges cover a wide range of complex issues, which are interrelated and detrimental to health. The still high population growth and pervasive poverty, especially in the hills, are primary contributing factors to most of the country's environmental problems. The main environmental issues are water pollution due to poor sewerage and sanitation, industrial discharge and wastes, and pesticides from agricultural sources. Air pollution is due to combustion of fossil fuels, vehicular emissions, industrial emissions and combustion of bio-mass. These have caused deterioration of air quality, especially in urban areas, resulting in respiratory and eye problems. The rapid urbanization has exceeded the capacity of municipal services to provide basic services and the concept of healthy cities is limited to discussion only. Administratively, the Nepal Environment Policy and Action Plan was adopted in 1993 and an Environmental Protection Council established in the same year. In 1995 a Ministry of Population and Environment was created. The main constraints in the implementation of environmental measures have been lack of resources and trained manpower, weak infrastructure and coordination, and lack of awareness on environmental issues.

3.2 Water supply and sanitation

The proportion of the population with access to safe drinking water in 1996 was reported to be 59% (urban 61%, rural 59%). It has however been stated that sewage lines run parallel to water mains, resulting in contamination during periods of low water pressure and in the presence of breakages in the systems, which has posed public health threats. The proportion of the population with adequate excreta disposal facilities is reported to be 23% (urban 74%, rural 18%). Priority has been accorded to safe drinking water supply and sanitation during the past two decades. Community involvement has been obtained to some degree. The main constraints have been rapid urbanization, diminishing spring water sources due to deforestation, and pollution of surface water sources by industrial waste and sewer lines fed into rivers.

SECTION 4: HEALTH RESOURCES

4.1 Human resources for health

Nepal continues to experience imbalances in the health workforce due to shortages of personnel and geographical maldistribution. Low productivity is related to poor working conditions, low remuneration and limited career opportunities. The number of health personnel in 2001/2002 in different categories were physicians 1,259 and nurses 6,216. Thus the number of physicians per 10,000 population was 0.54.

A master plan for the development of human resources for health has been finalized which addresses some of these issues. To meet human resource requirements at PHC level, the training of maternal and child health workers (MCHWs), auxiliary health workers (AHWs) and auxiliary nurse midwives (ANMs) is not confined to only the government but also entrusted to training institutes in the private sector. Some efforts have also been made to improve career development and motivate health personnel through improvements in their working environment.

4.2 Financial resources for health

The total national health expenditure for 2000 as a proportion of the GDP was 5.4%, the government health expenditure as a proportion of total health expenditure was 23.5%, and the total government health expenditure as a proportion of the total government expenditure was 6.2%. There has been an increasing trend in the allocation of financial resources for health sector development as part of the government's Poverty Reduction Strategy. There has been greater involvement of the private sector in establishing nursing homes, pharmacies, training institutes and even medical colleges. Among the main constraints identified are the wide gaps between committed and allocated funds, and between disbursed and reimbursed funds under the development scheme for the electoral constituencies, lack of delegation of authority, and lack of skilled personnel in financial management. To ensure efficient use of financial resources the government has introduced a three-year rolling plan for making financial projections, a decentralized budget system, and improved audit and financial systems. The implementation of the Local Governance Act promulgated in 1998 created conducive conditions for decentralization and shows first positive results.

4.3 Physical infrastructure

According to the National Health Policy a sub-health post (SHP) is to be available in each Village Development Committee (VDC) area. Similarly, one primary health center was to be established in each of 205 electoral constituencies. By 2001/2002, there were 3179 SHPs, 711 health posts and 180 primary health centers. The efforts of the government for strengthening the infrastructure, particularly in rural areas, are supported by the external development partners. The local communities play an increasing role in planning, establishing and managing their health infrastructures. The implementation of the Local Governance Act has resulted in developing community ownership of them. Constraints still to be overcome include poor building maintenance due to budgetary allocation, insufficient water supply or sewerage systems, only 13% have electricity, and only 29% have residential quarters. Standard items of furniture and equipment are lacking.

4.4 Essential drugs and supplies

A rough estimate of 40% has been made regarding the availability of essential drugs at remote facilities. A nationwide community based cost sharing programme is being implemented, which includes aspects such as training, supplies, monitoring and supervision. Responsibility of establishing co-ordination among governmental, non-governmental and private organizations involved in the activities related to drug production, import, export, storage, supply, sales, distribution, quality assessment, regulatory control, rational use and information flow. The main constraints are lack of adequately trained manpower, non-availability of transport when needed, and inadequate drug storage facilities.

4.5 International partnerships for health

The funding support through international partnerships for health expressed as a proportion of the total expenditure on health development increased from 40% in 1993 to 62% in 1996. This support has contributed much to the expansion of health facilities throughout the country. The main constraints include a gap between committed and allocated funds, as well as between allocated, disbursed and reimbursed funds due to low absorptive capacity; inconsistencies in the financial rules of the government and donor agencies; lack of delegation of authority in decision-making; and ineffective coordination. To overcome these shortcomings, a donor coordination committee has been formed in the Ministry of Health (MOH) to mobilize funds. The Finance Section of the Department of Health Services (DOH) is responsible for ensuring accountability in resource utilization. A Joint MOH/Donor Coordination Mechanism proves its usefulness in these processes. The main partners are WHO, UNICEF, UNDP, UNFPA, World Bank, GTZ, DFID, USAID, JICA, SDC.

SECTION 5: DEVELOPMENT OF THE HEALTH SYSTEM

5.1 Health policies and strategies

The National Health Policy (NHP) was formulated in 1991 and the 8th, 9th Five Year Plan and SLTHP were based on the policy objectives. The principal objective was to upgrade the health status of the majority of the rural population by strengthening the PHC system. The policy also refers to the gradual development of the Ayurvedic and traditional systems of medicine, improvement in the organization and management of health care services, community participation, development of human resources for health, resource mobilization, private sector and NGO participation, and decentralization/regionalization. In developing policies, strategies and plans, there is a process of broad consultation that involves the principal stakeholders from the community, the private sector, international and local NGOs, the government and the donor community.

5.2 Intersectoral cooperation

The National Planning Commission (NPC) provides overall leadership in ensuring intersectoral cooperation for health development. A government/WHO coordination committee also promotes intersectoral coordination. The main health programme areas for intersectoral cooperation are HIV/AIDS and STD control, Safe Motherhood, IEC for health, Health Management Information System (HMIS), Nutrition, and the National Immunization Programme. The main constraints are the weak links that exist in the area of intersectoral coordination, the low priority given to health by other sectoral ministries, and the lack of an agenda and a work plan for improving intersectoral coordination and cooperation.

5.3 Organization of the health system

Since the early 1990s, notable progress has been made in improving the PHC service network by establishing PHC centers, health posts and sub-health posts in a phased manner and improving outreach services by providing more female MCH workers, village health workers, and female community health volunteers at VDC level. Medical supplies, equipment and drugs have also been supplied to the extent possible. The central role of district health systems has been recognized, as has the need for supporting

government/private sector partnerships for health financing and cost sharing/recovery schemes in collaboration with international and local NGOs and other donor partners. Recent legislation has also been introduced to address issues that have hindered staffing of rural health facilities. The highly centralized decision making with limited delegation of authority, overlapping roles and responsibilities at various levels, and lack of support to the decentralization process with regard to decision making, planning, financing and management, have been constraints to better organization of the health system.

5.4 Managerial process

During the last years, considerable efforts have been undertaken for improving organizational and management aspects of health services delivery at central, regional and district levels. Positive examples are the integration of hospitals and public health offices into single District Health Offices in all but 14 districts, more focus on technical and administrative supervision, improving logistics for supplies, drugs and equipment, and making VDCs more responsible for essential services, including health.

To facilitate the managerial process, an integrated HMIS, a human resources development information system and a logistics management information system (LMIS) have been established within the DOH. In 1993 a master plan for development and utilization of human resources (revised in 1995) was prepared. In the planning process, the main constraints were the lack of inter and intra sectoral coordination, the central government retaining wide-ranging discretionary powers that limit decentralization in spite of district development and village development legislation, planning responsibility at regional levels but no authority, and lack of skilled manpower. The budgeting process is centralized with excessive reliance on incremental budgeting. There is a lack of supportive supervision with fault-finding mainly due to lack of managerial and technical skills among supervisors. Development of human resources for health is also a centralized process resulting in mismatch between supply and needs.

5.5 Health information system

In 1995, the establishment of a new Health Management Information System was completed. Since then, it has proved its usefulness for the management process. In the initial phase, only performance statistics at PHC level were obtained district wise. Subsequently, hospital morbidity and mortality statistics and other health service data were incorporated. The new integrated health information system is a simple, uniform recording and reporting system, applicable nationwide, and for the first time it has been possible to produce a complete integrated annual district health system (DHS) report. Regular feedback to districts and regions has had a positive effect on improving the completeness and accuracy of data as well as on the utilization of data.

5.6 Community action

The influence of community action has been reflected in rural areas through the involvement of health volunteers, e.g. female community health volunteers and trained TBAs. Other community action includes the formation of ward health committees, mothers' groups, women's coordinating committees, PHC/ health post/sub health post management committees and hospital helping committees. Various cost sharing/cost recovery schemes are

also in place. With the introduction of an easy registration system, there has been an upsurge of hundreds of NGOs participating in health service delivery at community level. However, monitoring and supervision of activities at community level are weak and need to be strengthened.

5.7 Emergency preparedness

During recent years, considerable developments have taken place in the areas of disaster awareness as well as Emergency Preparedness and Response. Under the leadership of the Epidemiology and Disease Control Division of the Department of Health Services a strong and active multi-sectoral working group has been established. It comprises Government authorities, local and international NGOs and external development partners. First results of its work were, among others, the wide dissemination of information to the public, training of a large number of health staff, and a structural assessment of hospitals in the Kathmandu Valley and other parts of the country. Emergency Preparedness and Response Plans are being formulated under the leadership of the Focal Point for Emergency Preparedness in the DoH.

5.8 Health research and technology

The Nepal Health Research Council is the main body for planning and coordinating research activities related to bio-medical and operational research. The Bulletin of the NHRC is used for informing decision-makers and researchers of new developments related to health. The provision of grants is a means for promoting young researchers. Action at community level helps to raise the understanding of the need for evidence based work and for the use of locally generated data and information. These and other activities are complemented by the research programmes of the institutions of medical education and selected NGOs specializing in research. Support provided by WHO and other development partners aims at capacity building, focussing on health priorities and effective use of research results.

SECTION 6: HEALTH SERVICES

6.1 Health education and promotion

The establishment in 1993 of a National Health Education, Information and Communication Center (NHEICC) under the Department of Health was a milestone in efforts at health promotion. This center was able to back up important health programmes such as safe motherhood, family planning, immunization, nutrition, HIV/AIDS etc. with impressive results. It has also been possible to streamline IEC activities after vertical programmes were integrated into general health services. The main constraints are a shortage of trained personnel, inadequate training of health personnel in communication skills, duplication of efforts vis-à-vis activities of NGOs, and shortage of funds. The NHEICC would need to coordinate government and NGO efforts to maximize the use of resources, monitor IEC activities, and make available IEC materials and expertise as and when required.

6.2 Maternal and child health/family planning

There have been some improvements in the MCH/FP indicators in Nepal though much still needs to be done. About 35% of pregnant women are attended by trained

personnel during pregnancy; 13.5% of deliveries are attended by trained health personnel (1999/2000). This means that the majority of women deliver at home without any form of trained assistance. The reported infant mortality rate (IMR) in 2001 was 64.2 per 1000 live births, the maternal mortality ratio (MMR) was 415 per 100,000 live births. The total fertility rate (TFR) 4.1 (2001/2002), and the contraceptive prevalence rate (CPR) 34.5% (1999/2000). Efforts are being directed at training TBAs and female community health volunteers as outreach health workers.

6.3 Immunization

The proportion of infants that have been fully immunized by their first birthday with all EPI vaccines was 43.3% (1996). The coverage of individual vaccines in 2001/2002 were DPT 80%, OPV 80%, measles 75% and BCG 95%. The proportion of women immunized with two doses/booster dose of tetanus toxoid (TT) during pregnancy was 24.2%(1999/2000) National Immunization Days and other related programme activities have been successfully carried out with the broad involvement of the communities and will ensure that Nepal can be certified polio-free by the year 2005. A well functioning Inter-agency Coordination Committee guides the partners involved in the planning and implementation of programmes supported by the Global Alliance for Vaccines and Immunization. Multi-agency efforts are being undertaken for up-grading and maintenance of the cold chain.

6.4 Prevention and control of locally endemic diseases

Nepal has a high burden of endemic communicable diseases, the most important ones being Malaria, TB, Kala-azar, Japanese Encephalitis, Filariasis. During the last years, HIV/AIDS has substantially contributed to the increase of this burden. Major progress has been achieved towards the elimination of Leprosy. Improvements in the response to disease outbreaks could be made through the establishment of an Early Warning and Response System (EWARS). The Vector-Borne Diseases Research and Training Center in Hetauda plays an important role in both research activities and training of health manpower in vector-borne disease control. Diagnostic capacities have been strengthened at various levels of the healthcare system. Health information and education of the public is being implemented in collaboration with NGOs and media.

6.5 Treatment of common diseases and injuries

There has been significant improvement in the diagnosis, referral and treatment of common diseases like acute respiratory infections (ARIs), diarrhoea, and nutritional problems, particularly with the enrolment of female community health workers who are equipped with simple drugs like ORS and vitamin A. An effective vitamin A distribution programme (biannual) has also been implemented. The main constraints are inadequate training of health workers and volunteers, lack of monitoring and supervision, and irregular supply of drugs. It is planned to involve NGOs in monitoring and supervision at community level.

SECTION 7: TRENDS IN HEALTH STATUS

7.1 Life expectancy

The life expectancy at birth has increased from 55 years for males and 53.5 for females in 1995 to 58.9 years (both male and female) in 2001/2002. The reduction in IMR has been a major contributory factor. The main constraints have been illiteracy, difficult terrain, lack of trained manpower, and limited resources.

7.2 Mortality

The registration of vital events is grossly inadequate in Nepal. Lack of data does not allow a realistic assessment of either mortality or morbidity. However, based on hospital data (1998/99), five leading causes of mortality were reported as Pneumonia, other cardio-pulmonary diseases, encephalitis/meningitis, septicemia and diarrhoea.

7.3 Morbidity

Information on morbidity is unreliable and is not classified by age or sex. The main causes of morbidity reported for 1999/2000 were skin diseases, diarrhoeal diseases, acute respiratory infections, intestinal worms, gastritis, pyrexia of unknown origin, ear infection, chronic bronchitis, anemia and abdominal pain.

7.4 Disability

The disabled are the most vulnerable and neglected group in Nepal. A survey in six districts estimates the prevalence of disability at 3%. The main disabilities are visual impairment (cataract and vitamin A deficiency) and hearing loss (suppurative otitis media). Preventive programmes associated with disability include vitamin A supplementation, iodization of salt, EPI, and prevention of accidents. The Association for the Disabled and the Association for the Welfare of the Blind have launched national programmes to educate the population regarding disabilities. The main constraints are the low priority given to disability, poverty, and inadequate health care provision.

SECTION 8: OUTLOOK FOR THE FUTURE

8.1 Overall assessment and strategic issues

Since early 1990s, some improvement in health status has been observed. Expansion of the primary health care network has been achieved by establishing PHC centers and sub-health posts at electoral constituency level and village development committee level respectively, together with the use of trained volunteer female community health workers for outreach services. Despite these initiatives, health status indicators reveal the fact that much more needs to be done. In this context the importance of establishing a reliable database needs to be emphasized. Poverty is a major concern and poverty alleviation is a prime goal in the 9th Five Year Plan (1997-2002). Assistance from international donor agencies still continues to play an important role in the provision of health care.

8.2 Future vision

The future vision of the government is to provide equitable access to quality health care services in both rural and urban areas. To achieve equity, access to health will need to be provided to vulnerable groups such as women and children, the rural and urban poor, the underprivileged, and marginalized population groups. To meet the main health problems of the people, the government will give priority to health promotion and prevention and to the development and implementation of a set of "Essential Health Care Services" (a priority package of public health measures and essential clinical services including traditional and other systems of medicine) that will be available to the entire population. Central to this vision of health and development is the recognition of self-reliance, gender sensitivity in health programmes, full community participation, private sector participation (public/private mix), and decentralization as characteristics essential to the health system.

8.3 Proposed strategies

The proposed strategies of the government will be:

- (1) ensuring equity for health,
- (2) strengthening health promotion and protection,
- (3) strengthening the health sector including partnerships in health development,
- (4) developing and strengthening specific health programmes,
- (5) developing and using appropriate health technologies, and
- (6) strengthening international partnerships.

Country reported data on basic health indicators*

Indicator	Latest available data	Year	Source	Remarks
Population and Vital Statistics				
Total population	23,214,681	2001/ 2002	6	Country update
Population density (persons per sq km)	158 ^a	2001/ 2002	6	Country update
Sex ratio (males per 100 females)	0.997	2001/ 2002	6	Country update
Population under 15 years (%)	39.4	2001	2	Country update
Population 60 years and above (%)	6.50	2001	2	
Crude birth rate (per 1000 population)	33.58	2001/ 2002	6	Estimates
Crude death rate (per 1000 population)	9.96	2001/ 2002	6	
Annual population growth rate (%)	2.27	2001/ 2002	6	Country update
Total fertility rate (per woman)	4.1	2001/ 2002	6	
Urban population (%)	14.20	2001	2	
Socioeconomic Situation				
Gross national product per capita (US\$)	224	1995/96	1	
Literacy rate (%): Total	53.74	2001	2	
Male	65.08	2001	2	
Female	42.49	2001	2	
Prevalence of low birth weight (weight <2500 grams at birth) (%)	23.2	1997	5	Country update
Prevalence of underweight (weight-for-age) in children <5 years of age (%)	47.1	1998	7	Children 6-59 months
Prevalence of stunting (height-for-age) in children <5 years of age (%)	54.1	1998	7	
Environment				
Population with safe drinking water available in the home or with reasonable access (%)	Total Urban Rural	59 61 59	1996 1996 1996	5 5 5
Population with adequate excreta disposal facilities available (%)	Total Urban Rural	23 74 18	1996 1996 1996	5 5 5
Health Resources				

* Note: Footnotes and source documents are listed at the end of this table

Indicator	Latest available data	Year	Source	Remarks
<i>Facilities</i>				
Number of hospital beds	6,654	2001/ 2002	6	Public and private
Population per hospital bed	3,489 ^b	2001/ 2002	6	
Hospital beds per 10,000 population	1.5 ^b	2001/ 2002	6	
Number of health centres	13	2001/ 2002	6	
Number of Primary health centres	180	2001/ 2002	6	
Number of health posts	711	2001/ 2002	6	
Number of subhealth posts	3,179	2001/ 2002	6	
<i>Human resources</i>				
Number of physicians	1,259	2001/ 2002	6	Public sector
Population per physician	18,439	2001/ 2002	6	Computed value
Physicians per 10,000 population	0.54	2001/ 2002	6	
Number of nurses	6,216	2001/ 2002	6	
<i>Budgetary resources</i>				
Total Expenditure on Health (THE) as % of Gross Domestic Product (GDP)	5.4 %	1998	8	
Public Expenditure on Health (PHE) as % of Total Expenditure on Health (THE)	23.5 %	1998	8	
Private Expenditure on Health (PvtHE) as % of Total Expenditure on Health (THE)	76.5 %	1998	8	
Public Expenditure on Health (PHE) as % of General Government Expenditure (GGE)	6.2 %	1998	8	
Social Security Expenditure on Health (SSHE) as % of Public Expenditure on Health (PHE)	0.0	1998	8	
Tax funded Health Expenditure (TaxFHE) as % of Public Expenditure on Health (PHE)	66.2 %	1998	8	
External Resources for Health (Ext Res HE) as % of Public Expenditure on Health (PHE)	33.8 %	1998	8	

Indicator	Latest available data	Year	Source	Remarks
Private Insurance for Health Risks (Pvt ins HE) as % of Private Expenditure on Health (PvtHE)	0.0	1998	8	
Out-of-Pocket Spending on Health (OOPS) as % of Private Expenditure on Health (PvtHE)	72.4 %	1998	8	
Per capita Total Expenditure on Health (THE) at official Exchange rate (X-Rate per US\$)	11	1998	8	
Per capita Public Expenditure on Health (PHE) at official Exchange rate (X-Rate per US\$)	3	1998	8	
Per capita Total Expenditure on Health (THE) in international dollars (int'l \$)	58	1998	8	
Per capita Public Expenditure on Health (PHE) in international dollars (int'l \$)	14	1998	8	
Health Services				
Pregnant women attended by trained personnel during pregnancy (%)	35	1999/2000	7	First ANC visit
Deliveries attended by trained personnel (%)	13.5	1999/2000	7	
Women of childbearing age using family planning (%)	34.5	1999/2000	7	Country update
Eligible population (i.e. infants reaching their first birthday) that has been fully immunized according to national immunization policies	82.5	2001/2002	6	
Infants reaching their first birthday that have been fully immunized against diphtheria, tetanus, and whooping cough (%)	80	2001/2002	6	
Infants reaching their first birthday that have been fully immunized against poliomyelitis (%)	80	2001/2002	6	
Infants reaching their first birthday that have been fully immunized against measles (%)	75	2001/2002	6	
Infants reaching their first birthday that have been fully immunized against tuberculosis (%)	95	2001/2002	6	
Women that have been immunized with tetanus toxoid (TT) during pregnancy (%)	24.24	1999/2000	7	

Indicator	Latest available data	Year	Source	Remarks
Health Status				
Life expectancy at birth (years)	58.95	2001/ 2002	6	Projections
Infant mortality rate (per 1000 live births)	64.2	2001/ 2002	6	Projections
Under-five mortality rate (per 1000 live births)	91	2001/ 2002	6	Projections
Maternal mortality ratio (per 100,000 live births)	415	2001/ 2002	6	Projections

^a Based on surface area of 147,181 square kilometer

^b based on estimated population of 23,214,681

- Sources:**
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