

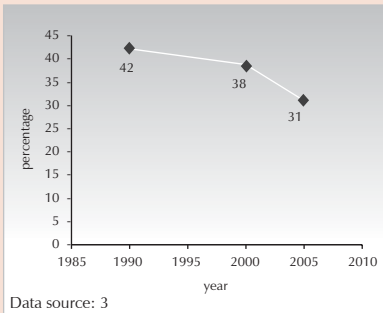


Nepal

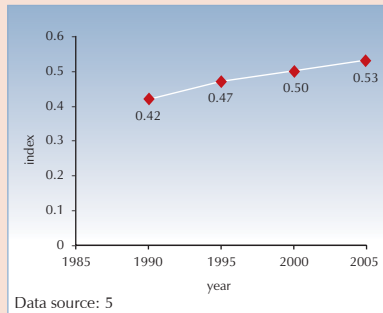
Basic information	Latest available value	Year	Source
Total population (million)	25.8	2006	{23}
Area (sq.km.)	147,181		{1}
Density of population (per sq.km.)	175	2006	{C}
Administrative divisions	5 development regions, 14 zones and 75 districts		

Development	Latest available value	Year	Source
Gross national income (GNI) per capita (US\$)	270	2005	{4}
Highest in the world – Norway	59590	2005	{4}
Highest in the Region – Thailand	2750	2005	{4}
Population below poverty line – Intl.\$1 per day (%)	24.1	2003-2004	{4}
Lowest in the Region – Maldives	<1	2004	
Population below national poverty line (%)	31	2005	{3}
Lowest in the Region – Maldives	8	2004	
Adult literacy rate >15 years (%)	49	2004	{5}
Highest in the Region – DPR Korea	100	2003	
Net enrolment ratio primary (%)	84	2005	{3}
Highest in the Region – DPR Korea	100	2003	
Human Development Index	0.527	2004	{5}
Highest in the Region – Thailand	0.784	2004	
Human Poverty Index (%)	38.1	2006	{5}
Lowest in the Region – Thailand	9.3	2006	
Gender-Related Development Index	0.513	2006	{5}
Highest in the Region – Thailand	0.781	2006	

Percentage of population below national poverty line



Human development index



Salient basics

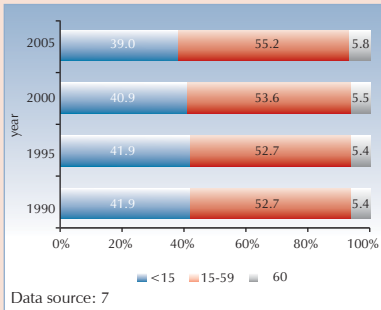
- Nepal is a landlocked country situated in the Himalayas.
- The Gross national income per capita (int \$) is 1530. Nearly one-third population lives below national poverty line.
- Literacy is low, but the human development index exceeds 0.5.

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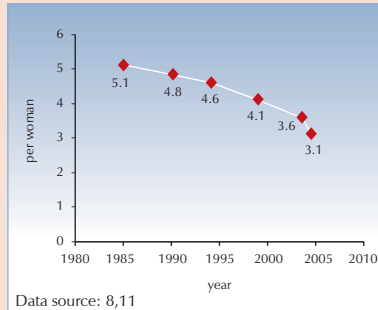
What are the basic demographic features?

Indicators	Latest available value	Year	Source
Population			
Total population (million)	25.8	2006	{23}
Population growth rate per year (%)	2.25	2001	{3}
Urban population (%)	14	2001	{1}
Age-sex structure			
Sex ratio (F/1000M)	1000	2001	{1}
Children <15 years (%)	39	2001	{1}
Elderly >60 years (%)	6	2001	{1}
Highest in the world – Italy, Japan	26	2005	{7}
Highest in the Region – DPR Korea	12	2002	
Dependency ratio (%)	85	2001	{C}
Fertility			
Birth rate (per 1000 population)	28.4	2003-2005	{8}
Lowest in the world – Germany, Ukraine	8.0	2004	{10}
Lowest in the Region – Thailand	12.7	2002	
Total fertility rate (TFR) (per woman)	3.1	2003-2005	{8}
Lowest in the world – Ukraine	1.1	2004	{9}
Lowest in the Region – Thailand	1.6	2000	
Contraceptive prevalence (%)	48	2003-2005	{8}
Gross mortality			
Crude death rate (per 1000 population)	9.9	2001	{6}
Lowest in the world – UAE	1.0	2004	{10}
Lowest in the Region – Maldives	3.0	2005	

Percentage of population in different age groups



Total fertility per women



Salient demographic features

- Nearly 85% of the people live in villages, in remote and difficult to access terrain.
- The population is predominantly children and the growth rate is high. Decline in fertility is slow but has accelerated recently.
- Total fertility is nearly three times the lowest in the world.

2

What is the progress regarding some health-related MDGs?

Indicators	1990	2000	2005	2015 (Target)
Poverty and hunger				
Population below minimum level of dietary energy consumption (%)	49	47	N/A	25
Under-weight (<-2SD) children aged 6-59 months (%)	57	48	38.6 (2006)	29
Child mortality				
Infant mortality rate (per 1000 live births)	108	64	48 (2006)	34
Under-five mortality rate (per 1000 live births)	162	91	61 (2006)	54
One-year-olds immunized against measles (%)	42	71	85	>90
Maternal health				
Maternal mortality ratio (per 100,000 live births)	515	415	281	134
Deliveries attended by health staff (%)	7	11	18.7	60
HIV/malaria/tuberculosis				
HIV prevalence in 15-49 years (per 100,000 population)	N/A	290	500	
Malaria prevalence (per 100,000 population at risk)	196	52	25	
Tuberculosis prevalence (per 100,000 population)	460	310	280	
Tuberculosis cases detected (%)	N/A	69	71	
Water and sanitation				
Population with access to improved water source (%)				
Combined	36	67	73	73
Rural	33	65	71	72
Urban	67	79	83	95
Population with access to improved sanitation (%)				
Combined	6	30	39	53
Rural	3	25	30	52
Urban	34	80	81	67

MDG progress

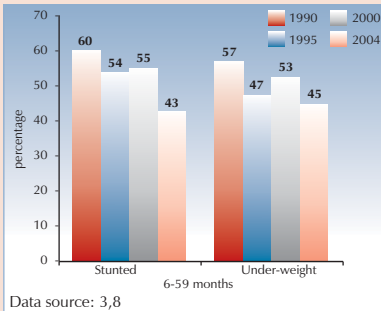
- Some targets, such as for water and sanitation and immunization have been achieved or are likely to be achieved. Others, such as for mortality and nutrition remain a challenge.

3

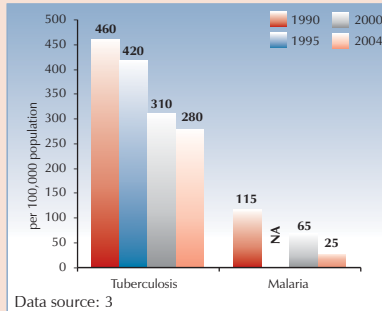
What are the major health problems?

Indicators	Latest available value	Year	Source
In children under five years			
Low birth weight (%)	14.3	2006	{23}
Lowest in the Region – Indonesia	6	2002	
Stunted children (%)	49.3	2006	{23}
Lowest in the world – Croatia	1	1998-2004	{10}
Lowest in the Region – Sri Lanka	14	2000	
Under-weight children (%)	38.6	2006	{23}
Lowest in the world – Chile, Croatia, Ukraine	1	1998-2004	{10}
Lowest in the Region – Thailand	9	2003	
Childhood diseases			
Diarrhoeas-reported cases incidence (per 1000 children <5 years)	11	2003-2004	{11}
Acute respiratory infections – reported cases incidence (per 1000 children <5 years)	8	2003-2004	{11}
Other diseases			
Tuberculosis prevalence (per 100,000 population)	280	2005	{3}
Malaria prevalence (per 100,000 population)	25	2005	{CC}
HIV prevalence (per 100,000 population) – 15-49 years	500	2005	{3}
Diabetes prevalence (per 100,000 population)	1982	2000	{18}
Comprehensive indices			
Expectation of healthy years lost (years)			
Male	7.4	2002	{12}
Female	9.1	2002	{12}
As % of expected life at birth (ELB) lost			
Male	12.4	2002	{12}
Female	15.1	2002	{12}

Nutritional status of <5 years children by year



Prevalence of tuberculosis and malaria by year



Major health problems

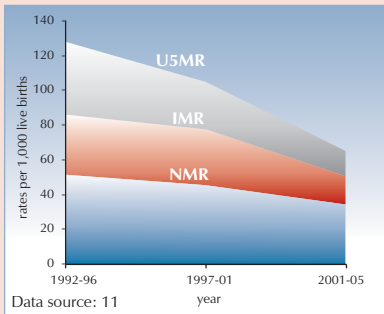
- Nepal's epidemiological transition is slow. Expectation of life is around 61 years.
- In women, nearly 15% of life's equivalent healthy years are lost due to diseases.
- Under-nutrition is wide-spread, particularly among children.
- HIV is emerging as a problem and tuberculosis continues to be a major threat.

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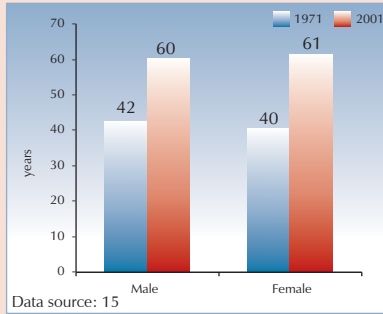
What is the mortality profile?

Indicators	Latest available value	Year	Source
Mortality rates			
Neonatal mortality rate (NMR) (per 1000 live births)	34	2001-2005	{8}
Lowest in the world – Singapore	1	2000	{9}
Lowest in the Region – Maldives	8	2005	
Infant mortality rate (IMR) (per 1000 live births)	48	2006	{23}
Lowest in the Region – Sri Lanka	11	2003	
Under-five mortality rate (U5MR) (per 1000 live births)	61	2006	{23}
Lowest in the world – Iceland, Singapore	3	2004	{10}
Lowest in the Region – Maldives, Sri Lanka	16	2005	
Maternal mortality ratio (per 100,000 live births)	281	2006	{23}
Lowest in the Region – Thailand	14	2003	
Age at death			
Expectation of life at birth (ELB) (years)	61	2004	{13}
Highest in the world – Japan, Monaco	82	2004	{13}
Highest in the Region – Maldives, Sri Lanka	73	1996-2001	
Deaths under-five years (% of total deaths)	24	2005	{C}
Lowest in the Region – Thailand	4	2002	
Causes of death (percentage of total deaths)			
Three major causes of deaths (0-14 years) – Males			
Pneumonia	13	2001	{1}
Diarrhoea	12	2001	{1}
Measles	3	2001	{1}
Three major causes of adult deaths (≥15 years) – Males			
Asthma/Bronchitis	9	2001	{1}
Tuberculosis	5	2001	{1}
Cancer	4	2001	{1}
Three major causes of deaths (0-14 years) – Females			
Pneumonia	12	2001	{1}
Diarrhea	12	2001	{1}
Complication of Pregnancy and Delivery	9	2001	{1}
Three major causes of adult deaths (≥15 years) – Females			
Asthma/Bronchitis	9	2001	{1}
Cancer	5	2001	{1}
Complication of Pregnancy and Delivery	4	2001	{1}
Tuberculosis death rate (per 100,000 population)	23	2000	{3}
Tuberculosis deaths (% of total deaths)	3	2002	{20}
Cerebrovascular disease deaths (% of total deaths)	5	2002	{20}

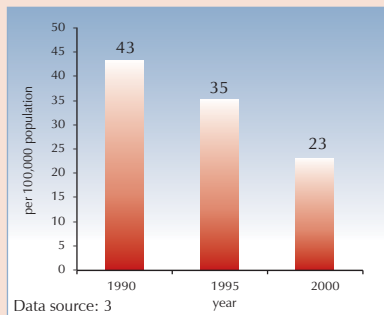
Mortality rates of children



Comparison of expectation of life at birth between males and females by years



Tuberculosis death rates



Mortality profile

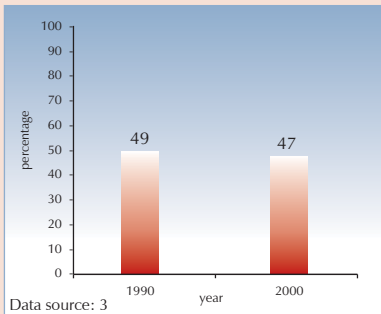
- Nearly a quarter of deaths occur in children less than five years.
- Major causes of death are infections, particularly for child deaths among children.
- Diseases of the respiratory system are the major causes of deaths among adults.

5

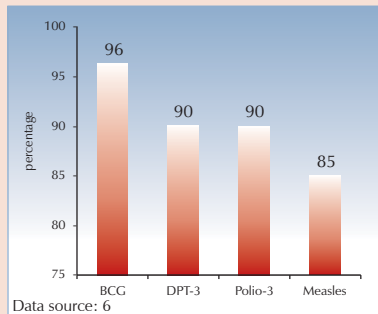
What resources are available for the health sector?

Indicators	Latest available value	Year	Source
Expenditure on health			
Percentage of GDP	5.3	2003	{12}
Highest in the world – USA	15.2	2003	{12}
Highest in the Region – Timor-Leste	9.6	2003	
Per capita (US\$)	12	2003	{12}
Per capita (Intl.\$)	64	2003	{12}
Highest in the world – USA (Intl.\$)	5711	2003	{12}
Highest in the Region – Maldives (Intl.\$)	364	2003	
Food			
Average dietary energy consumption (kcal/day/person)	2450	2001-2003	{14}
Services			
Primary health centres (per 100,000 population)	0.8	2001-2002	C
Antenatal care coverage (at least one visit) (%)	44	2006	{23}
Deliveries by qualified attendant (%)	18.7	2006	{23}
Children immunized (%)			
BCG	87	2005	{24}
DPT-3	75	2005	{24}
Polio-3	78	2005	{24}
Measles	74	2005	{24}
Hospital beds (per 10,000 population)	50	2006	{CC}
Highest in the world – Monaco	196	1995	{9}
Highest in the Region – DPR Korea	132	2002	
Human resources			
Doctors of modern system (per 10,000 population)	2	2004	{9}
Highest in the world – Cuba	59	2002	{13}
Highest in the Region – DPR Korea	32	2003	{13}
Nurses (per 10,000 population)	2.0	2004	{13}
Highest in the Region – DPR Korea	37	2003	{13}
Auxillary Nursing Midwives (per 10,000 population)	2.4	2004	{13}
Dentists (per 10,000 population)	0.1	2004	{13}
Pharmacists (per 10,000 population)	0.1	2004	{13}
Public and Environmental Health Workers (per 10,000 population)	0.1	2004	{13}
Community Health Workers (per 10,000 population)	6.3	2004	{13}
Lab Technicians (per 10,000 population)	1.2	2004	{13}
Other Health workers (per 10,000 population)	0.7	2004	{13}

Percentage of population below dietary requirements



Percentage of immunization coverage 2003-04



Health resources

- Health expenditure at 64 Intl.\$ per capita is low.
- Basic facilities such as safe drinking water and sanitation, doctors, nurses and beds continue to be inadequate, particularly in rural areas.
- Immunization has picked up but antenatal coverage and deliveries by skilled attendant deserve more attention.

6

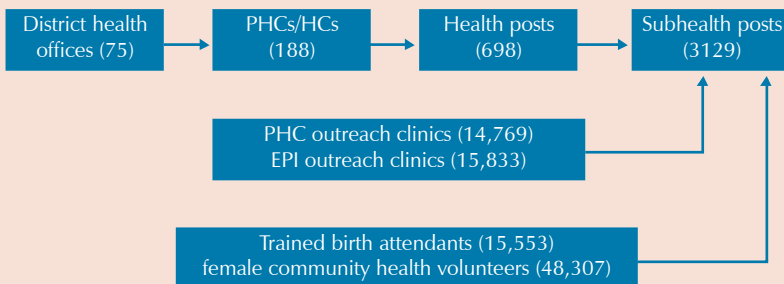
What is the system of health governance?

Organization

Nepal's Ministry of Health has three departments:

- Department of Ayurveda
- Department of Health Services
- Department of Drug Administration

The Department of Health Services has six divisions (Management, Family Health, Child Health, Epidemiology and Disease Control, Logistic Management, and Leprosy Control). Recently, Leprosy Control has been designated as a section under Epidemiology and Disease Control. It runs five technical centres (Tuberculosis, Training, Health Information and Communication, AIDS and STD Control, and Public Health Laboratory). There is a Training Centre and a Medical Store in each of the five Regions but there is only one Regional Hospital, one Regional Laboratory and one Regional TB Centre. There are zonal Hospitals in 11 of the 14 zones. Each of the 75 districts has a District (Public) Health Office but the number of district hospitals is only 62.



Primary Health Care Centre/Health Centre (PHC) is delimited to the electoral constituency. Out of 205 such constituencies, PHCs are present in 188. These are served by 698 Health Posts and 3129 SubHealth Posts. Volunteers such as 15,553 Trained Birth Attendants (TBAs) and 48,307 Female Community Health Volunteers (FCHVs) also refer the cases to the health facilities. FCHVs focus on motivation and education of mothers and community members for the promotion of

safe motherhood, child health, family planning, and other community health services. The system also works as a supportive mechanism for lower levels by providing logistical, financial, supervisory and technical support from the centre to the periphery.

Ancillaries

- Nepal has a Reproductive Health Steering Committee at the central level and a Reproductive Health Coordination Committee in 33 districts.
- The Safe Motherhood programme now covers most of the districts.
- For year-round availability of essential drugs, a Community Drug Programme has been initiated in most of the districts.
- The Department of Drug Administration has developed and distributed a Standard Treatment Schedule for Health Posts and SubHealth Posts to encourage and enforce rational use of drugs. The Nepal Drug Research Laboratory tests and analyse medicines and works as the national drug control laboratory.
- There are some non-profit hospital and many private-sector hospitals in urban areas. Out of a total of 9881 hospital beds, 2285 (23%) are in the private sector.
- There is a NCD focal point with a NCD committee consisting of subcommittees on Diabetes Mellitus, Cancer, Mental Health and Oral health.

Private sector

The health care system is mostly run by the government. Yet, nearly one-third beds are in the private sector. These comprise those run by NGOs such as missions, Lions clubs and associations. There are also some private nursing homes. Due to recent rapid growth, there are at least 9 private hospitals and at least 10,000 private pharmacies in the country.

Traditional system

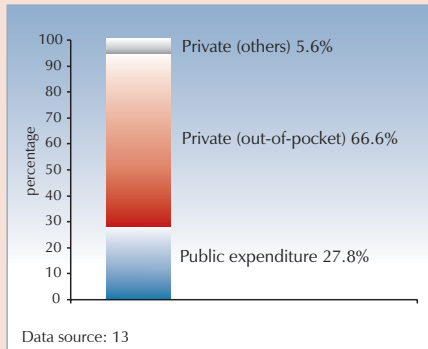
A large segment of the population benefits from the Ayurveda system, mostly in conjunction with the modern system. The Department of Ayurveda runs one central level hospital (100 bedded)—Naradevi Ayurvedic Hospital with specialized services, one Regional Hospital (30-bedded) in Dang, 14 Zonal Ayurvedic Dispensaries, 59 District Ayurveda Health Centres and 214 rural dispensaries. Nearly 200 doctors are registered with the Nepal Ayurveda Council. This department also supports homeopathic and Unani medicines although they are not practiced on a large scale.

7

Who pays for health care?

Indicators	Latest available value	Year	Source
Government expenditure on health			
Out of total health expenditure (%)	28	2003	{13}
Per capita (US\$)	3	2003	{13}
Per capita (Intl.\$)	18	2003	{13}
Highest in the world – Monaco (Intl.\$)	3403	2003	{13}
Highest in the Region – Maldives (Intl.\$)	324	2003	
Private expenditure on health			
Out of total health expenditure (%)	72	2003	{13}
Per capita (US\$)	9	2003	{C}
Per capita (Intl.\$)	46	2003	{C}
Lowest in the Region – DPR Korea	0.4	2004	
Out-of-pocket expenditure (% of private expenditure on health)	92	2003	{13}
Per capita (US\$)	8	2003	{C}
Per capita (Intl.\$)	42	2003	{C}
Lowest in the world – Tuvalu	13	2003	{13}
Lowest in the Region – Timor Leste	26	2004	
Insurance coverage			
Social security expenditure on health out of general govt. expenditure on health (%)	<0.5	2003	{13}

Health expenditure



Health expenditure

- Despite widespread poverty, government expenditure on health is meagre. Nearly three-fourths is met by private sources, mostly out-of-pocket.
- Social security for health care is limited.

8

What are the recent reforms and achievements of the health system?

Health sector reforms

- A Health Sector Reforms Committee has recently have established under the Chairmanship of the Health Minister. The Committee is expected to plan and coordinate the resources available for health sector programmes from all contributors. The group is expected to mobilize more resources and increase the fund absorption capacity of the system.
- For planning health sector reforms, 14 studies have been carried out on the health situation in different areas, and initiatives taken to extend the health services to all segments of the population.
- There is a policy now for greater involvement of the private sector in hospital services.
- Information systems are developing well. The Health Management Information System (HMIS), Logistics Management Information (LMIS), and Fiscal Management Information System (FMIS) are taking shape. Since the initiation of FMIS, staff have been trained, forms designed and regular reporting made more strict.
- An external development forum was established in 2004. Since 2005, this forum holds discussion twice a year with the Government on annual planning and evaluation in a Joint Annual Review using the Nepal Health Sector Programme Implementation Plan as a reference

Achievements

- The Health budget is 6% of the national budget.
- Breastfeeding is nearly universal with a median duration of 34 months. Feeding within the first hour of birth and within the first day, which was low, has improved in the last few years. But exclusive breastfeeding is still low.
- Hepatitis B has been added to EPI across the whole country.

Legislation

- The Smoking (Prohibition and Control) Act 2001 is awaiting parliament approval. A five-year (2004-08) action plan has been devised to control smoking. Smoking in public places is banned and advertisements are not allowed. There is a health tax on tobacco products and excise duty on tobacco has been increased.
- The Diesel-driven 3-wheelers are banned in Kathmandu. Vehicles older than 20 years must be taken off the road.
- Eleventh amendment to the civil code has legalized abortion services under certain conditions. The government has recently approved the Safe Abortion Service Procedures 2004. Accordingly, the Maternal Hospital in Kathmandu has started providing abortion-related services since March 2004.
- A quality assurance policy draft and Noncommunicable Disease policy draft are in the process of being endorsed.
- A mental health legislation draft is in the process of being endorsed.

9

What are the constraints and challenges of the health system?

Financial constraints

- GNI is only 1530 international dollars per capita, and 31% of the population is below the national poverty line. For health, 6% of the national budget is allocated.
- Distribution of funds is mainly urban-centric. In addition, only 68% of the budget allocated is actually utilized.
- People spend a significant amount of money on health care from their pocket.

Expertise and other physical constraints

- Although lack of trained manpower including physicians and inadequate infrastructure are definite problems the bigger problem is due to inadequate management.
- Health awareness in the population is poor.
- A combination of the above two has led to a shortage of auxiliary nurse mid-wives (ANMs), problems with referral, maternity homes not operationalized in many districts, low antenatal care coverage, and low coverage of deliveries by skilled attendant.

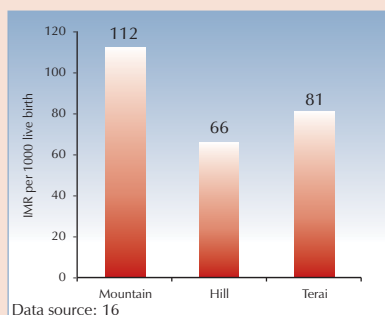
Health sector constraints

- Those include poor management of public sector health facilities and institutions, poor compliance with existing guidelines and quality of care protocols; lack of awareness about roles and responsibilities of health functionaries; absence of an effective system to ensure quality and fair pricing of private sector services; and clear policies for human resource development and management.
- Because of resource constraints and inadequate motivation of the health staff, PHCs are not able to deliver proper services and

Indicators	Latest available value	Year	Source
Social constraints			
Inequalities – Gender			
Expectation of life at birth F:M	1.00	2004	{13}
Female share in employment (non-agricultural sector) (%)	18	2000	{3}
Seats held in parliament – F (%)	5.8	2000	{3}
Ratio of girls to boys in primary schools (%)	86	2004	{3}
Inequalities – Spatial			
Total fertility rate (per woman)			
Urban	2.1	2003-2005	{8}
Rural	3.3	2003-2005	{8}
Infant mortality rate (per 1000 live births)			
Urban	37	2006	{23}
Rural	64	2006	{23}
Water supply(%)			
Urban	93	2005	{3}
Rural	79	2005	{3}

Females are at a disadvantage, and there are area-wise inequalities exist.

Ecological distribution of infant mortality rate in 2001



are not able to attract the needy. Only 9% of deliveries in 2001 were conducted in a health facility and only for 13% a health professional was present. This increased upto 20% in 2005. A major constraint is the lack of physicians and nurses at PHC level, particularly the remote areas, where most of the posts are vacant.

- Many people may have faith in alternative medicine, particularly Ayurveda, but the facilities available for this system are meagre.

- Information systems have improved but have their limitation in providing critical information needed to evaluate the health system and to take immediate corrective steps.
- The laboratory network needs to be strengthened to support communicable diseases diagnosis and to establish outbreak etiology.

Challenges

Nutrition

- The high incidence of low birth-weight and under-weight and stunted children underscores the need to substantially increase the emphasis on nutrition. Particular attention is needed for maternal and child nutrition.
- Seasonal "hunger gaps" during winter, droughts and monsoon in pockets of rural areas undermine food security.

Health services

- There is a need to strengthen PHCs to meet all basic health needs of the people.
- Outreach programme for antenatal care and deliveries by trained workers need strengthening.
- In many places, the hospital manager is a clinician who also has to deal with outpatient.

Public health

- Nepal is one of the few countries where leprosy is yet to be eliminated.
- The public health system capacity has to be improved to respond in a timely and efficient manner to handle outbreaks.
- A Laboratory-based, integrated disease surveillance system covering both the public and private sectors needs to be initiated.

Training the staff

- Training facilities should be augmented for women to be qualified ANMs. The government is upgrading the Maternal and Child Health Worker to ANM by providing additional training.
- All vacant positions in the health sector should be filled and steps taken to fully utilize the funds ear-marked for health.

The work culture

- The staff should be motivated to do better through a system of rewards and recognition, or any other mechanism considered appropriate.
- Duties for each category of staff for which (s)he can be held responsible should be clearly notified. Supervision should be strengthened so that any lapse can be immediately rectified.
- Pockets that are doing well or can do better should be identified, and the feasibility to use them as examples for others to emulate examined.

10

What does the country hope to achieve in the near future in health?

The second Long-Term Health Plan (1997-2017) of Nepal, aims to benefit the most vulnerable—women and children, the rural population, the poor and the under-privileged, and the marginalized. It aims equitable access by extending quality services to remote areas with full community participation and gender sensitivity by technically competent and socially responsible health personnel. The main targets are as follows:

- Reduce infant mortality rate from 75 per 1000 live births to 34.
- Reduce under-five mortality from 118 per 1000 live births to 61.
- Reduce total fertility rate from 4.58 to 3.05.
- Increase life expectancy from 56 to 69 years.
- Reduce maternal mortality ratio from 475 per 100,000 live births to 250.
- Increase the contraceptive prevalence rate from 30% to 58%.
- Reduce low weight births to 12%.
- Provide essential health care services to 90% of the population within 30 minutes of travel.
- Make essential drugs available round the year in 100% of facilities.
- Equip 100% facilities with full staff to deliver essential health care services.
- Increase total health expenditure to 10% of total government expenditure.

MDG targets are an improvement over the targets in the national plans, and should be achieved sooner.

All this is proposed to be achieved by:

- Developing an effective health system for the provision of affordable and accessible essential health care services.
- Promoting a public-private partnership for the promotion of health care.

- Decentralizing the health system and ensuring a participatory approach at all levels.
- Improving the quality of health system by total quality management of human, financial, and physical resources.
- Strengthening and expanding Ayurveda services by which locally available medicinal plants, encouraging a positive attitudes towards health care, and establishment of three regional Ayurvedic hospitals and a research centre.

How is WHO collaborating with the country?

Policy development and planning

- WHO initiated a sector-wide approach for joint planning and programming based on the second Long-Term Health Plan and health section of the 10th Five-Year Development Plan. Also technical support to the MDGs, Health Sector Strategy and Nepal Health Sector Programme Implementation Plan was provided.
- Commission on Macroeconomics and Health that may scale-up essential health care services and help in reaching the poor was supported.
- The establishment of an Apex Body to promote coordination among the Ministry of Health, different eye hospitals, and development partners including NGOs in the planning and implementation of blindness prevention activities was supported.
- The key areas identified for country cooperation are: equitable health care financing; increased access of the underprivileged to services; integrated disease surveillance; prevention and control of communicable and chronic diseases; rationalization of human resource development and management; reduction of maternal and neonatal mortality; promotion of healthier physical environment; and health system capacity building for emergency preparedness and response.

Health system management

- WHO supported the establishment of a joint steering committee for identification of Essential Health Care Services for strengthening the district health system. WHO advocating and supporting decentralization of health services.
- Support has been provided for the development and implementation of the clinical protocol and case management guidelines for strengthening the capacity for the Safe Motherhood Programme at central, regional and district levels, and for enhancing coordination with other development partners and NGOs.

Promotion of healthy lifestyles and settings

- Support has been provided and priority given for health promotion activities in all collaborative programmes including environmental health, water and sanitation, tobacco control, noncommunicable diseases, violence and injuries. WHO is supporting the NCD risk factor survey in four districts
- Water supply and environmental sanitation is high on the agenda. Food hygiene and food safety have yet to gain significant momentum although health education of the public on these aspects has been a priority program over the years.
- WHO is providing community mental health and psychosocial support for post-conflict rehabilitation.

Prevention and control of priority diseases

- The Polio Eradication Programme is continuing to get assistance. Jointly with UNICEF, WHO supported the formation and the work of the Inter-agency Co-ordination Committee and also provided support for the Global Alliance for Vaccines and Immunization (GAVI).
- WHO maintains a strong relationship with many partners in the leprosy elimination programme, particularly a whole range of INGOs. In its future work, WHO will further support the efforts of the government towards eliminating leprosy.
- There is strong collaboration between WHO and the National Tuberculosis Centre, which is also the SAARC tuberculosis centre.
- The Blindness Prevention Programme is very active and is benefiting WHO's VISION 2020 initiative as well as inputs from national and international NGOs.
- WHO is championing kala-azar elimination in Nepal in the context of the regional initiative involving Bangladesh, India and Nepal.
- Support has been provided for the development and implementation of the National Avian Influenza and Influenza Pandemics Preparedness and Response Operational Plan in partnership with the World Bank, FAO, UNICEF and UNDP.
- The National Malaria Control Programme receives continued assistance and support especially in creating the evidence base for decision making.
- WHO is backstopping the Lymphatic Filariasis Elimination Programme by ensuring the monitoring and surveillance component and critical supplies.

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