UHC

Research on Universal Health Coverage (UHC) for Migrants in Nepal

Research Conducted by
POURAKHI NEPAL
October, 2022

Acronyms

STDs	Sexually transmitted diseases
HIV	Human immunodeficiency virus
AIDS	Acquired immunodeficiency syndrome
MWs	Migrants Workers
UHC	Universal Health Coverage
SDGs	Sustainable Development Goal
BHCP	Basic health care package
MoHP	Ministry of Health and Population
FHCP	Free basic health care
HIB	Health Insurance Board
SSF	Social Security Fund
OOP	Out-of-pocket
FHCP	Free Health Care Programme
EPF	Employee Provident Fund
DOHS	Department of Health Services
CSO	Civil Society Organization
CSEM	Civil Society Engagement Mechanism
HDC	Health Data Collaborative
DOFE	Department of Foreign Employment
MOLESS	Ministry of Labour, Employment and Social Security
NGO	Non-Governmental Organization
NPISH	Non-Profit Institutions Serving Households
PLHIV	People Living with HIV
SRHR	Sexual Reproductive Health and Rights
ILO	International Labour Organization
NHPC	Nepal Health Professional Council
NMC	Nepal Medical Council
NWC	National Women Commission
WHO	World Health Organization
NHRC	National Human Rights Commission

Chapter 1

INTRODUCTION

1.1 Context

Labour emigrants' health rights are not addressed, which makes migrants and their families vulnerable to STDs like HIV/AIDS, opportunistic infections and they were severely affected due to COVID-19 Pandemic. Inequity in access to healthcare is still a major barrier for labour migrants in migrant workers' (MWs) sending and receiving countries in Asia due to discriminatory health policies, non-recognition of labour migrant's health rights, fragmented health systems, insufficient resources and an insufficient awareness level on utilization of available health services which are main factors hindering access to health services for MWs and Universal Health Coverage. Between 2017 and 2019, Nepal's Universal Health Coverage (UHC) service coverage index increased from 48% to 53%; less than 50% of the required rate to attain the Sustainable Development Goals (SDGs). Consequently, the government prioritized health data availability at all levels to support more equitable health service delivery, with a particular focus on those left behind. A cost-free, basic health care package (BHCP) was to be delivered through local governments as a gateway to achieving UHC. With SDG3 GAP as a roadmap and with support from SDG3 GAP institutions, the government has developed a National Action Plan for 2020-2022. In line with this plan, the Ministry of Health and Population (MoHP) has put primary health care and health data acceleration solutions high on its agenda.

Nepal's 2009 and 2015 Constitutions stipulated the country's Universal Health Coverage (UHC) with the goal of institutionalizing UHC through the Health Sector Strategy (2015–2020), which emphasizes the importance of helping vulnerable groups. Lay the foundation for the path to To achieve this goal, three social health insurance schemes were established: the Health Insurance Bureau (HIB), the

Social Insurance Fund (SSF), and the Employee Provided Fund (EPF). Despite these efforts, the coexistence of different systems has led to fragmentation and inefficiency (Nepal Ministry of Health and Population 2018; Sharma, Aryal, and Thapa 2018). As a result, high out-of-pocket (OOP) burdens are a major challenge in ensuring access to health services for all.

Despite these initiatives, HIV and AIDS coverage in MW's sending countries in South Asia no longer recognize migrants as a key population, and their health vulnerabilities are largely ignored. As a result, CARAM Asia, in collaboration with its participants in Nepal, Pakistan, Bangladesh, and Sri Lanka, will conduct behavior studies aimed at influencing political representatives, government officials, and organizations to reduce fitness inequities and ensure fairness in all policies, programs, offerings, and data measures to protect labor migrants' fitness rights and inclusion in sending and receiving countries. In this regard, CARAM Asia has engaged with POURAKHI to perform a "research project to know where the country is on the road to universal health coverage (UHC) for all with a focus on migrants" in Nepal. This research was conducted with the aim of focusing on influencing political representatives, government officials, and agencies to reduce health inequities and to steward health and equity in all policies, programs, services, and information measures to safeguard the health rights and inclusion of labor migrants in sending and receiving countries. To address human rights and the consequences of health inequities, current strategies need to be reinvigorated and combined with new strategies that facilitate powerful and sustainable coverage interventions to reduce health inequities and mitigate the health-associated dangers for the duration of the migration cycle.

1.2 Objectives of the Study

The objectives of the research are:

A) To identify priority areas for immediate funding and urgent needs related to migrant health issues at country level.

B) Tool 1: Use the UHC survey template to find out where the country is currently on her way to UHC in general and with a focus on MW’s health rights.

Ultimately, the results will allow us to explore potential areas of action in the health systems to increase capacity and capacity of stakeholders to reduce inequities through the collaborating actions and demand to increase the health budget.

1.2 Desk Review

Under this research POURAKHI Nepal conducted a desk study to review health policies and available information on the national health systems.

The constitution of Nepal enshrines basic health care as a basic right of citizens. Now that the country has transitioned to federal system of governance, it is the state's responsibility to ensure that all citizens have access to quality health care services based on the contextual norms of the federal system. Article 35 of the Nepalese Constitution mentions the right to health as follows: (1) All citizens shall have equal access to medical services; and (2) all citizens shall have the right of access to safe drinking water and sanitation.

The National Health policy, 2019 was formulated on the basis of a constitutional list of exclusive and concurrent powers and functions at the federal, state and local levels. Policies and programs of the Government of Nepal; International Commitments Nepal has made at various times. Also, issues, challenges, available resources and evidence in the health sector. These policies served as the basis for interventions towards UHC and the development of national health insurance schemes (Dahal et al. 2017). The public Health Services Act came into force in late 2018 and emphasized the right of all citizens to quality healthcare.

Numerous public health programs have been implemented over the years in Nepal to improve access to health services. In particular, the aforementioned Free Health Care Program (FHCP) 76 was created by the 2006 and 2009 Free Health Care Policy to provide free targeted care, free universal care, free primary health care and free hospital care was introduced in four stages. The Employee Provident Fund (EPF) Health Insurance Plan for Government Employees was established in late 2013 pursuant to the Employee Provident Fund Act 2019 (1962). FHCP provides free basic medical services through the FHCP, as well

as emergency services and inpatient and outpatient care in public facilities. For other groups, supplementary benefits are covered by the 'Social Health Insurance Scheme', i.e. SSF, EPF, HIB.

The issue of foreign worker movement is addressed in the Constitution, on the basis of which various immigration guidelines and legal frameworks have been drafted to regulate the movement of foreign workers. To address the changing labor dynamics situation and issues related to foreign workers, the Regulations on Overseas Employment was revised in Nepal in 2008. Times have been amended. In the case of Nepal, the existing policy emphasizes that the regulation and management of foreign employment should be safe, systematic and free from exploitation of any kind, and the capital, skills, technology and we encourage the use of experience in hiring people. Regulating economic interests rather than focusing on migrant health security.

The positive trends of constitutional provisions, global support, progress in health insurance legislation, decentralization of healthcare at the grassroots level, and increased benefit coverage are seen as opportunities. However, the main challenges are the existing voluntary forms of health insurance, the misleading role of trade unions and the high proportion of the expatriate population. Political commitment, national priorities, and international support in a changing political climate were identified as enabling factors for UHC.

****

Chapter 2

RESEARCH METHODOLOGY

2.1 Research Design

A qualitative approach was chosen to conduct this study. This research is primarily based on desk reviews and is supported by stakeholder consultations and interviews with key stakeholders.

2.2 Nature and Source of Data/Information

Both primary and secondary data were collected in this study. Mainly, secondary data was collected from official government documents, books, journals, research reports and various archives. However, questionnaires were employed to collect primary information. Information was collected using qualitative research techniques such as group discussions and interviews. In conducting the work, due consideration was given to research ethics, and the consent of the respondents was obtained before the interview. Likewise, great care was taken not to harm informants. Participants were verbally asked open-ended questions in both individual interviews and focus group discussions. These methods were used in the study because they allow for a participatory approach that encourages the participants to freely discuss, analyze and share their opinions on research-related issues. Moreover, these methods saved time during the investigation and increased cost efficiency.

2.3 Techniques of Data Collection

The study used the following combination of quantitative and qualitative approaches.

Literature review: A review of existing policies, legal frameworks and mechanisms governing the movement of health workers from Nepal was undertaken.

Mapping of stakeholders and institutions: A mapping of formal and informal institutions and organizations related to the migration and health sector in Nepal was made.

Interviews: Interviews were conducted with a range of stakeholders known about the dynamics behind the migration and health, with a particular focus on the UHC. Interviews were conducted with representatives of his CSOs, government agencies, and other relevant stakeholders that deal with immigration and health rights for migrant workers.

2.3 Limitation of the Study

The research team encountered many challenges during the course of their research. The target dates for his research activities were not met for two reasons. The interview is unable to attend due to busy schedules at work or festival sessions; another difficulty the research team faced was getting the correct answers from the selected interviewees. The research team faced a major challenge gathering enough information for the study from several interviews.

****

Chapter 3

DATA/INFORMATION ANALYSIS AND FINDINGS

Nepal, a landlocked country in South Asia, has a population of 28 million people with a life expectancy of 69 years for men and 72 years for women. Nepal gears towards addressing equity gaps and focuses on making health services accessible via the introduction of free health care programs, targeted health package schemes, and a safe delivery incentive scheme. Despite the significant increase in government expenditure on health, out-of-pocket expenditure remains high. The Nepal Health Sector Strategy 2015–2020 provides a road map towards universal health coverage (UHC) and prioritizes health system improvement in human resources for health, public financial management, infrastructure, procurement, and health governance. Both health policy and health strategy are in line with the Sustainable Development Goals. Since 2018, the UHC Partnership (UHC-P) has supported the finalization of basic health care service packages and strengthened capacity building regarding health service delivery at all levels. The development of a health financing strategy and technical support regarding the strengthened health management information system are also part of the cooperation with the UHC-P.

Universal health coverage (UHC) ensures all types of health services and financially protects all citizens in any illness-related situation. Globally, the UN sustainable development goal (SDG) provides high priority for UHC as a health-related goal. Similarly, Nepal's national health system has prioritized. Nepal has UHC partnerships. The Nepal Health Sector Strategy 2015–2020 provides a road map towards universal health coverage (UHC) and prioritizes health system improvement in human resources for health, public financial management, infrastructure, procurement, and health governance. Both health policy and health strategy are in line with the Sustainable Development Goals. Since 2018, the UHC Partnership (UHC-P) has supported the finalization of basic health care service packages and strengthened capacity building

regarding health service delivery at all levels. The development of a health financing strategy and technical support regarding the strengthened health management information system are also part of the cooperation with the UHC-P.

Nepal has developed joint JFAs with partners as a tool to manage external development assistance for health to align with national plans and priorities. Some observers consider these documents more important than the Compact. At the same time as developing the Compact, work began in Benin to take forward the Health Systems Funding Platform to better harmonize health systems and strengthen support behind the national plan. This work is ongoing, and the platform has just been launched. There has been work in Nepal to draft an agreement on joint technical cooperation to improve harmonization. In Nepal, it was suggested that the multitude of documents and arrangements has caused confusion about the distinct purpose of each document or agreement, the relationship between them, and the list of signatories to each agreement. This may also be the case in other countries with multiple agreements, and Nepal has UHC legislation.

Nepal has a national health policy, which was started in 2019 and is publicly available, and the government of Nepal has a department that engages across sectors for the specific purpose of improving health, which is the Department of Health Services (DOHS). Nepal does not have laws and policies in place to ensure that vulnerable people can engage in the planning, budgeting, and monitoring of health plans and budgets. Nepal has published a national roadmap to UHC. The targets made by Nepal on UHC are for basic health services, social health protection arrangements, and health service delivery tiers.

The national debates, discussion in the parliament's budget speech, or public consultation on UHC are happening in Nepal. Last year, the country spent NPR 90.69 billion on health, a decrease from the previous year. Nepal has a national health insurance scheme. The National Health Insurance Policy was passed by the Government of Nepal in 2014. The ordinance for the formation of the Social Health Security Development Committee was passed and published in the Nepal Gazette on February 9, 2015. The insurance coverage is as follows;

- PR 3,500 (35 USD) per year for a family of up to 5 members.
- NPR 700 (7 USD) for every additional family member.
- 2% payroll contribution for the formal sector.
- 100% subsidy for families of ultra poor, HIV, MDR-TB, Leprosy, severe disability patient
- 100% subsidy for elderly population above 70 year

Because Nepal has a national health insurance scheme, no alternative is in place. Promotive, preventive, and curative services are included in the government's Health Benefit Package. Outpatient, inpatient, and emergency care are all available. There are numerous free services and medications available. As an example: Health-care facilities, both public and private NPR 100,000 (1000 USD) per family/year for up to 5 members, with an additional NPR 20,000 (200 USD) for each additional member [up to a total of NPR 200,000 (2000 USD)]. Each elderly population receives an additional NPR 100,000 (1000 USD), and patients with eight chronic diseases receive an additional NPR 100,000 (1000 USD).

"POURAKHI NEPAL" has consolidated and gathered information in the following thematic areas as part of this research, which is explained below;

a) Leave no onebehind

The Government of Nepal has defined 'Universal Health Coverage (UHC)' which guarantees all kinds of medical services and financially protects all citizens in all disease-related situations. Globally, the United Nations Sustainable development Goals (SDGs) gives UHC a high priority as a health related goal. Nepal's national health system has set similar priority as a health-related goal. Nepal's national health system has set similar priorities. UHC is measured by different metrics: financial coverage and service coverage.

Nepal is focused on closing the equity gap and is increasingly focused on making services available to those in need. We have implemented free health programs, targeted health packaging systems, and safe delivery incentive systems to minimize the equity gap. Nevertheless, the country still faces many health problems. The latest Nepal Health Facilities Survey addresses the challenges of providing quality health

services, ensuring adequate skilled manpower and ensuring regular availability of basic necessities to provide essential health care. Recent research also reveals disparities in service use by gender, age, education level, geography and wealth quintile, suggesting the overall impact of health services on morbidity and mortality in equitable strata. Need to understand better. Availability of disaggregated data, data analysis capabilities for stock monitoring, and improved visualization and access to information are key areas that need further work to ensure that no one is left behind.

"Health plans and policies do not currently identify which populations are being left behind. Nor are they specifically targeted to the populations most in need."

The government of Nepal defines marginalized and vulnerable groups as communities who are politically, economically and socially disadvantaged and who are inaccessible or deprived of services and facilities due to discrimination and oppression increase. It is mentioned in federal law and includes highly marginalized and endangered groups.

However, this definition does not explicitly assign these groups to drug users, sex workers, prisoners, immigrants, and health insurers. In interviews, it was reported that the program aims to increase access to health services for the poor and marginalized, as well as for those in hard-to-reach areas of the country, but funding still have challenges. Moreover, there are no specific legal or policy frameworks that explicitly support access to health services or quotas or designated services by vulnerable groups.

These health policies and plans do not address the social and environmental determinants of health. However, the Foreign Employment Board (FEB) provides welfare-related activities for immigrants and their families such as kills development, mentoring, repatriation and integration, and compensation for injuries and deaths suffered by migrants in the workplace.

b) Public financing for health

The Ministry of health and population (MoHP) budget proposal is submitted to the Ministry of Finance (MoF) and the National Planning

Commission (NPC) for discussion and final decision on the ministerial budget. The budget preparation process begins each year in the first week of February and ends in May. Each level of government and its subdivisions must develop budgets and programs for the coming year in order to receive resources. The budget should be divided into economic expenditures based on the approved "Combined Code of Revenues and Expenditures for All Her Three Levels of Government" 2074. Budget and program proposals should be based on the goals and objectives of the Medium-Term Expenditure Framework (MTEF) regular plans, as well as the GoN's international commitments and annual plans and policies.

Donors have played a key role in financing Nepal's public health expenditure, but their share of total funding has decreased from 42% in FY 2010/22 to 21% in FY 2019/20.6. Health and Education are prioritized to raise the Human Development Index (HDI) from 0.602 currently to 0.65. COVID-19 cases fell and the budget allocation to the Department of Health and Population was cut by 16% to NPR 103.09 billion (US$845 million) as a percentage of the total state budget. The current share of annual GDP spent on health is 4.45% of total GDP as of 2019. In recent years, it has not increased gradually. No steps have been taken to phase out patient fees; instead they have increased since the pandemic.

There is no evidence that donor governments provide funding in accordance with country plans, aid effectiveness principles, or the WHO recommendation that funding levels not fall below 0.1% of GNP. The Government of Nepal relies heavily on patient cost/OOP payments to fund its healthcare system. The UHC plan included several measures to eliminate patient costs/OOP payments, such as free medication and free health checkups, as well as costs for insulin and other essential medicines.

c) Involvement of CSOs and citizens, transparency and accountability at all levels

Civil society is not expected to be involved in all stages of UHC decision-making, from conception and budgeting to implementation, to monitoring and evaluation at the national or community level. Since then, community feedback to government to assess the quality of services provided by local authorities has been through petitions,

letters and joint statements. Similarly, steps can be taken to ensure that the voices of the most marginalized and vulnerable communities are included and heard in the design, planning, budgeting and implementation of health-related programs. National health plans and policies are accompanied by health financing strategies supported by the ministry of Finance, and CSOs are committed to expanding health services to reach marginalized and vulnerable groups.

However, while community-led surveillance approaches are neither recognized nor valued, civil society organizations (CSOs) play a key role in building a strong, justice-focused, people-led UHC movement plays through a broad consultation process, the CSO established the UHC2030 Civil Society Engagement Mechanism (CSEM) on behalf of its constituents. Civil society representatives can advance health, financing and governance issues related to achieving UHC. The UHC plan does not include specific measures to combat tax evasion and avoidance.

d) Support health workers

In the case of Nepal, Health workers do not have adequate working conditions and wage levels because the health system does not have enough health workers. Health Policy does not adequately recognize that women make up 70% of health workers and only 25% of managers. However, health workers may be trained on how to support the future health needs of marginalized and vulnerable groups in general. The government funds both state and local health worker training and development, but not enough. UHC policies, plans and reports focus less on MW's right to health and more on UHC healthcare workers and investments in Nepal.

Health status in Nepal is segmented along various dimensions such as wealth, caste and place of residence. Macro-level gains in healthcare are still poorly reflected in micro-level gains, hindering access to healthcare facilities even after government investments in the healthcare sector.

****

HEALTH FOR ALL

Chapter 4

DATA/INFORMATION ANALYSIS AND FINDINGS

4.1 Conclusion

Nepal's health sector is characterized by large urban-rural disparities, contributing to the fact that only one-third of Nepalese households have access to health facilities within 30 minutes of their homes. In this context, the lack of sickness benefits for the majority of the population is an additional factor limiting access to care when needed. Equality, although formally abolished in Nepal, remains a significant barrier to access to healthcare. Recent surveys and studies have also revealed differences in service use by gender, gender, age, level of education, geography and wealth quintile, giving better picture of the overall impact of health services. It is necessary to understand.

Overlapping target groups of systems make parallel systems inefficient, lead to public confusion about qualifications, and limit overall coverage. Similarly, in the early stages of discussion on health insurance legislation, it was envisioned that all full-time employees would be required to enroll in HIB, but this has not materialized. His OOP payments account for a very high proportion of healthcare costs in Nepal due to the increasing use of privately provided healthcare services. Various government policies to provide free healthcare in public facilities have enabled greater access, but the growing market share of poorly regulated private facilities has led to a response and his OOP is increasing. This trend is exacerbated by the limited coverage provided by Nepal's social health insurance mechanism.

Signatories of both the Global Action Plan for Healthy Lives and Well-Being for All (SDG3 GAP) and the Health Data Collaborative (HDC), including Gavi, Global Fund, UNAIDS, UNFPA, UNICEF, WHO and the World Bank Other HDC members, such as the organization German Institute for International Cooperation (GIZ), are working with the

Nepalese government to enhance routine data sources, demographics and population-based surveys to improve the health care for Nepalese. These agencies also support data management capacity building at national and local levels. However, the autonomy of local decision makers and their capacity to plan health interventions for those most in need has not yet been fully strengthened. Legal guarantees are the first step in moving forward with universal coverage. Legal protection is possible after political commitment, political approval, and the design of a specific program. The main breakthroughs and opportunities are the constitutional guarantee of health insurance for all citizens, the revision of the Health Insurance Law, the discussion of health financing policies, and the expansion of social health insurance. Inadequate recognition of risk pooling approaches in the case of treating disease is a big challenge. Achieving UHC can be achieved in a different way by developing a financial protection system that covers all marginalized people, quality health services and comprehensive challenges including emerging and re-emerging diseases. I have to think. Health service performance and population coverage must be scaled up, along with financial protection for marginalized communities. Government leadership, stakeholders support, equitable contributions and resource allocation through appropriate health financing methods can accelerate UHC efforts in Nepal.

4.2 Recommendation

The Nepal Demographic and Health Survey (2016) reported that nearly half (47%) of the households have at least one family member who migrated in the last 10 years, either to internal or international destinations. These migrant workers contribute over a quarter of the country's gross domestic product through remittances from abroad. The migration outflow consists predominantly of low-skilled male workers, primarily to Malaysia and the GCC countries. Labour migration contributes significantly to the sociocultural and economic development of both origin and destination countries. However, migrant workers experience specific vulnerabilities and face a range of health risks while working abroad. These risks are particularly significant for Nepalese workers in the GCC countries, as they are often employed in occupations considered "difficult, dirty, and dangerous" (3Ds). The findings suggest the urgent need for progressive policy

changes, both in Nepal and in destination countries, to better protect the health of labour migrants and improve their access to essential health services and acceptable working conditions.

1. To achieve UHC, strong government leadership is required. External development partners (EDPs) are only concerned with their own interests, whereas the government's role would have a broader impact. Restructuring health services at the center, province, and local levels, upgrading the health information system through online availability, and involving private health facilities in quality health care are all significant positive factors. The main factors impeding achievement are political ignorance about health services as a result of the previous service delivery structure, improper coordination among departments and divisions under MoHP, a lack of dynamism in the health system, and a donor-dependent health financing approach, among others.
2. In recent years, many programs have been implemented and much has been accomplished in Nepal to pave the way for UHC. Over the next few years, it will be critical to raise public awareness about the benefits of social health protection and to coordinate the development of existing mechanisms.
3. The National Health Sector Strategy outlined important principles for further development of the health care system as well as strategies to drive progress toward UHC in Nepal, including the explicit goal of harmonizing the various schemes. A good starting point in this context is the use of a uniform IT system, with work currently underway to enable SSF to use the same system as HIB, namely open IMIS. A shared database would provide an important foundation for future evaluations and evidence-based decisions.
4. The census data are used to determine health program coverage and population characteristics; however, due to large internal and foreign migration, discrepancies occur over time. While robust CRVS can provide nearly 25% of SDG indicators related to mortality, the absence of cause of death is a major issue in the system. Furthermore, coverage

and timeliness of birth registration are suboptimal, and infants unregistered at birth are often from marginalized communities, which adds to inequities of service access and the use of inaccurate denominator estimations, as well as underestimated vaccination targets, as recently demonstrated during the pandemic. Hospital service records need to be improved for completion, compliance, quality, and digitization.

5. The decentralized governance system in Nepal has a mandate to contribute to fragmented data production. An assessment of data gaps for health-related SDGs showed significant limitations in the availability of disaggregated data to monitor equity and understand the health situation at local levels.

6. Labour migrants fill out an exit form and an entry form. These forms do not ask for any health-related information. Some of the recruiting companies submit the pre-departure medical assessment reports to DPHO, which sends this data to HMIS of the Department of Health Services. However, HMIS currently does not include this information in its system. Similarly, the migrant health-related data captured by DoFE and FEB is not integrated in the HMIS either. HMIS currently does not identify any records related to migrant health.

7. The FEB records the deaths and disabilities of only the labour migrants who have taken labour permits. The description and categorization of causes of deaths in the FEB database (cardiac arrest, heart attack, natural cause, and other or unidentified causes) are not scientific as per the International Classification of Diseases and do not explain the actual or underlying cause.

8. Most migrants had difficulty accessing healthcare services in their destination. The major barriers to access were the lack of insurance, low wages, and not having an identification card or legal status. Other barriers were unsupportive employers, discrimination at healthcare facilities, and

limited information about the locations of healthcare services.

9. Labour migrants' health issues and their consequences should be part of labour agreements between host countries and Nepal. Health insurance in case of injuries, compensation for families in case of deaths, and further full investigations (autopsies) in the host countries should be mentioned in the agreement.

10. The government of Nepal should examine the health issues encountered by undocumented migrants and incorporate them into the policy. A health check-up of returnee migrants should be a mandatory provision upon their arrival at the Kathmandu Airport. Additional medical testing must be added based on the findings of the frequent health issues faced by migrants in the destination country.

11. Civil society must advocate for the inclusion of UHC advocacy in order to reduce fragmentation and competition among health initiatives, strengthen health systems, and promote a human rights-based approach to health.

****

Chapter 5

REFERENCES

Nepal Health Sector Strategy 2015-2020

https://www.uhcpartnership.net/country-profile/nepal/

https://www.uhc2030.org/fileadmin/uploads/ihp/Documents/Key_Issues/Country_Compacts/Developing%20a%20Country%20Compact.What%20Does%20it%20Take.Dec2012.pdf) Page no.9/2.4

https://www.researchgate.net/publication/306373795_Nepal's_quest_for_Universal_Health_Coverage#:~:text=The%20National%20Health%20Policy%202014,one%20of%20the%20policy%20strategies. Page no.104/1st paragraph

https://publichealthupdate.com/national-health-policy-2019-nepal/

https://dohs.gov.np/about-us/department-of-health-services/#:~:text=The%20overall%20purpose%20of%20the,Health%20%26%20Population (MoHP)

https://www.herd.org.np/uploads/frontend/Publications/PublicationsAttachments1/1480582316-Health%20Budgeting%20and%20Financing%20in%20Nepal%20-%20Policy%20Perspectives.pdf

https://www.uhcpartnership.net/country-profile/nepal/#:~:text=The%20Nepal%20Health%20Sector%20Strategy,infrastructure%2C%20procurement%20and%20health%20governance.

https://nepal.unfpa.org/sites/default/files/pub-pdf/NHSS-English-Book-final-4-21-2016.pdf) Page no.53

Budget-2020/21/Pg 8-12

https://publichealthupdate.com/social-health-security-health-insurance-program-in-nepal/#:~:text=National%20Health%20Insurance%20Policy%20was,published%20in%20the%20Nepal%20Gazette

https://publichealthupdate.com/social-health-security-health-insurance-program-in-nepal/#:~:text=National%20Health%20Insurance%20Policy%20was,published%20in%20the%20Nepal%20Gazette.

https://archpublichealth.biomedcentral.com/articles/10.1186/s13690-019-0331-7#:~:text=Universal%20health%20coverage%20(UHC)%20assures,has%20prioritized%20in%20similar%20way.

https://www.hfgproject.org/wp-content/uploads/2015/02/Indicators-for-Measuring-Universal-Health-Coverage-A-Five-Country-Analysis-DRAFT.pdf Pg 11-30

https://apps.who.int/iris/rest/bitstreams/609582/retrieve

https://www.who.int/news-room/feature-stories/detail/nepal20214th paragraph

https://www.mohp.gov.np/downloads/Constitution%20of%20Nepal%202072_full_english.pdfPg219 https://pubmed.ncbi.nlm.nih.gov/26300556/https://

nepaleconomicforum.org/key-highlights-of-budget-2022-23/#:~:text=The%20Government%20of%20Nepal%20(GoN,upcoming%20fiscal%20year%202022%2D23

https://www.theglobaleconomy.com/Nepal/health_spending_as_percent_of_gdp/

https://www.healthaffairs.org/do/10.1377/forefront.20150720.049382

https://www.startribune.com/unitedhealthcare-to-eliminate-out-of-pocket-costs-on-insulin-and-other-critical-drugs/600190597/

https://www.uhcglobal.eu/legal/Unitedhealthcare-uk-2021-tax-strategy.html

https://www.uhcglobal.eu/legal/Unitedhealthcare-uk-2021-tax-strategy.html

https://kathmandupost.com/national/2021/12/12/how-pandemic-ate-up-a-huge-chunk-of-budget

https://nepaleconomicforum.org/key-highlights-of-budget-2022-23/#:~:text=The%20Government%20of%20Nepal%20(GoN,upcoming%20fiscal%20year%202022%2D23

https://www.theglobaleconomy.com/Nepal/health_spending_as_percent_of_gdp/

https://www.healthaffairs.org/do/10.1377/forefront.20150720.049382

https://www.startribune.com/unitedhealthcare-to-eliminate-out-of-pocket-costs-on-insulin-and-other-critical-drugs/600190597/

https://www.uhcglobal.eu/legal/Unitedhealthcare-uk-2021-tax-strategy.html

https://www.uhcglobal.eu/legal/Unitedhealthcare-uk-2021-tax-strategy.html

https://kathmandupost.com/national/2021/12/12/how-pandemic-ate-up-a-huge-chunk-of-budget

https://imadr.org/nepal-earthquake-csos-joint-statement_30apr2015/

https://www.uhc2030.org/what-we-do/voices/civil-society-engagement/

https://www.recordnepal.com/no-doctors-for-hospitals#:~:text=Overall%2C%2044.5%20health%20workers%20are,(ANM)%20stands%20at%208%2C263.

http://www.salaryexplorer.com/salary-survey.php?loc=151&loctype=1&job=15&jobtype=2#:~:text=A%20person%20working%20in%20Patient%20Care%20in%20Nepal%20typically%20earns,%2C%20transport%2C%20and%20other%20benefits

https://www.thet.org/health-for-all-and-health-above-all/

https://www.who.int/nepal/news/detail/06-06-2021-eleven-thousand-healthcare-workers-trained-on-how-to-care-for-critically-ill-covid-19-patients

https://www.fiercehealthcare.com/payers/unitedhealth-invest-100m-diversifying-healthcare-workforce

****

Chapter 6

QUESTIONNAIRES

- Which global UHC collaborations has your government signed up to?
- Does your country have a Country Compact or 'pre-Compact' on UHC with development partners?
- Does your country have UHC legislation? Your country may use the term 'health reforms' rather than UHC.
- Does your country have a national health policy or strategic plan? What period does itcover? Is it publicly available?
- Does your government have a coordinationmechanism/department that engages across sectors for the specific purpose of improving health or advancing UHC?
- Are there laws and policies in place to ensure that people can engage in planning,budgeting and monitoring of health plans and budgets?
- Has your country published a nationalRoadmap to UHC?
- What public commitments and targets hasyour country made on UHC?
- Has there been any national debate, discussion in parliament budget speech orpublic consultation on UHC?
- What did your country spend on health last year? Has the amount increased ordecreased over time?
- What is the process and timetable forsetting the health budget?
- Does your country have a national healthinsurance scheme? What does it cover?
- If your country does not have a national health insurance scheme, what is in place?
- What is in the Health Benefit Package covered by the government? Which servicesand medications are available at no charge? How does your government define 'universal coverage'?Target: 100% of the population
- How is UHC being measured?
- Do health plans and policies identify which populations are currentlyleft behind and have insufficient access to health services; do these plans and policies explicitly target those populations most in need?
- Are health data disaggregated by sex, age, gender identity, race, ethnicity, income, disability and migratory status to accurately identifywho is being left behind?
- How does your government define marginalized and vulnerablegroups?

- Does this definition include people who use drugs, sex workers,prisoners, migrants etc.?
- Do health insurance schemes cover these groups? If not, why not?
- Are there laws and policy frameworks that explicitly support vulnerable groups to access health services? Are there quotas orearmarked services?
- Do health policies and plans address the social and environmental determinants of health?
- What is the current percentage of the health budget in relation to the overall government budget? Over the past few years, has there been any increase? Target: 15% (Abuja Declaration)
- What is the current percentage of annual GDP spent on health? Overthe past few years, has it progressively increased? Target: At least 5%Gross Domestic Product (GDP) is a standard measure of a country'stotal wealth.
- What proportion of health funding comes from external donors?
- Do donor governments provide funding in alignment with countries' plans, the aid effectiveness principles and the WHO recommendationthat funding levels are not below 0.1% of GNI?
- Does the government still rely on patient fees/OOP payments to fundthe health system?
- Do UHC plans include specific action points to abolish patient fees/OOP payments?
- What steps have been taken to phase out patient fees/OOP payments?
- Do UHC plans include specific action to address tax evasion andavoidance?
- What steps have been taken to address tax evasion and avoidance?
- If the government is not increasing its spending on health services,what is preventing this?
- Is civil society engaged at all stages of UHC decision-making, fromdesign and budgeting through to implementation, monitoring and evaluation?
- At the national level, are there opportunities for people, civil society organizations, and the private sector in your country to be engaged in planning, budgeting, monitoring and evaluating the health sector?
- At the community level, are communities engaged in local level health planning, budgeting and accountability processes, and are there feedback mechanisms for communities to assess the quality ofservices provided by local authorities?
- What steps have been taken to ensure the voices of the most marginalized and vulnerable communities are included and heard?
- Are country health plans and policies accompanied by a health care financing strategy supported by the Ministry of Finance?*
- Are CSOs engaged in expanding health services to reachmarginalized and vulnerable groups?

- Are community-led monitoring approaches recognized and valued?
- Are civil society accountability mechanisms included in UHC implementation plans?
- Are there sufficient numbers of health-care workers in the health care system?
- Do health workers have decent working conditions and levels of pay?
- Does health policy acknowledge that women make up 70% of the health workforce but only 25% of senior roles?
- Do health workers receive training on how to support the health needs of marginalized and vulnerable groups?
- Are training and capacity-building for both government and community health workers earmarked and adequately funded by the government?
- Do UHC policies, plans, and reports include a focus on investing in the health workforce?
- What is the process and timetable for setting the health budget?
- Do health plans and policies identify which populations are currently left behind and have insufficient access to health services; do these plans and policies explicitly target those populations most in need?
- What proportion of health funding comes from external donors?
- What steps have been taken to phase out patient fees/OOP payments?
- Do UHC plans include specific action to address tax evasion and avoidance?
- If the government is not increasing its spending on health services, what is preventing this?
- What steps have been taken to address tax evasion and avoidance?
- Do donor governments provide funding in alignment with countries' plans, the aid effectiveness principles and the WHO recommendation that funding levels are not below 0.1% of GNI?

****

POURAKHI Nepal
Address: House # 61, Chundevi, Madhur Marg,
Ward # 4, Maharajgunj, Kathmandu
Hotline number: 9849135206
Email: pourakhi@mail.com.np
Website: https://pourakhi.org.np/