

Research Report
on
Assessing the progress of health-related SDGs indicators for Nepal

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Research Report

Report on Assessing the progress of health-related SDGs indicators for Nepal

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Background

Following the remarkable global mobilization towards development made by MDGs, the UN General Assembly adopted the new development agenda called “Transforming our world: the 2030 agenda for sustainable development” on 25 September 2015 (1). This agenda is the central UN platform for achieving ‘integrated and indivisible’ Sustainable Development Goals (SDGs) across three broad dimensions: social, environmental and economic. The SDGs have 17 total goals, 169 targets, and 230 indicators leading up to 2030 which were built upon the outcome document of the UN Conference on Sustainable Development (Rio+20 Conference) (2).

Health is one of the core components of SDGs which is reflected in goal 3: good health and wellbeing. The targets of goal 3 encompass diverse health issues, from averting road accidents to reducing substance abuse and improving environmental health along with other straight forward and traditional issues covered in the millennium development goals (3). Better health and well-being is not only viewed as a single goal for sustainable development, but is regarded as being essential for achieving all three pillars of sustainable development (4). Moreover, health is also regarded as a precondition indicator, as well as an outcome of successful sustainable development (5). Core health issues described in goal 3 are also linked as a contributor to and beneficiary of other goals, such as nutrition (SDG 2), violence against women (SDG 5), water and sanitation (SDG 6) and birth registration (SDG 16) (6).

Nepal showed good progress in attaining health related millennium development goals (MDGs) [e.g. successfully achieved or partially achieved all targets of goal 4,5 and 6 of MDGs: reducing the infant mortality rate (IMR), reducing the under-five mortality rate (U5MR), increasing immunization against measles, reducing the maternal mortality ratio (MMR), increasing the proportion of births attended by skilled birth attendants (SBAs), and standing in the pre-elimination phase for malaria with a substantial reduction in malaria incidence and zero death rates.](7) However, the improvement is not fully consistent and major disparities are observed across rural/urban settings and eco-geographical regions (7).

Learning from the successes and challenges of MDGs, the SDGs present a set of context specific challenges for the health sector in being able to advance whole-of-systems, whole-of-government and whole-of-society approaches that leave no one behind (6). Besides for country like Nepal, challenges exist within budgetary issues, mobilizing and utilizing resources. Considering these challenges and limitations, it is a prerequisite to undertake a comprehensive and integrated approach including all the relevant stakeholders from both public and private sectors in order to achieve the targets. Because, "The SDGs are about everyone, everywhere; for everyone, everywhere; and they need to be by everyone, everywhere (8)". At the same time, regular basis independent and indicator based performance monitoring are also essential to ensure accountability and healthy lives and promote well-being for all at all ages. Because, we cannot afford a lag of several years before we start to measure progress towards achieving the SDGs.

Nepal has already set a good example to measuring activities and generating evidence during the MDGs period through strong commitment, transparency and independent monitoring. Although Nepal achieved most of the MDGs targets fully or partially, there were some unfinished agendas. Those unfinished agendas were incorporated in the SDGs (7). In addition, Nepal also set their SDG baseline in 2015 following the experience of MDGs and outcomes of Rio+20 (9). Later, the Planning Commission of Nepal conducted an another comprehensive study to update Nepal's SDG indicators and their 2030 targets, and set stage for accelerated implementation of the sustainable development agenda (10).

SDGs have passed a considerable amount of time, and it's time to track the relevant activities and measure progress which require greater investments in building independent, impartial national statistical capacities and strengthening quality and standards (11). Although countries who are implementing SDGs are not obliged to take into account any additional or parallel data generated through voluntary or civil society led monitoring, still external monitoring is exclusively helpful following the concerns over the lack of strong accountability mechanisms in the MDG framework (12,13). Besides, if there is no accountability mechanism to make states and other powerful actors more answerable to the people whose lives and rights they affect, progress maybe difficult to achieve (12).

The current study was conducted in order to measure the progress of health related SDGs indicators for Nepal against the SDGs baseline.

Objectives

General Objective: The general objective of this study is to assess the progress, challenges, and opportunities in attaining the health related SDG indicators of Nepal.

Specific Objectives

The specific objectives are:

- To review the baseline and analyze the trend of health-related SDGs for Nepal
- To explore data sources and identify data gaps for measuring the health-related SDGs

To explore the perceived challenges and opportunities by the program planners, implementers and policy makers in attaining health related SDG indicators in Nepal

Methodology

We adopted a mixed method approach for better understanding of the study objectives.

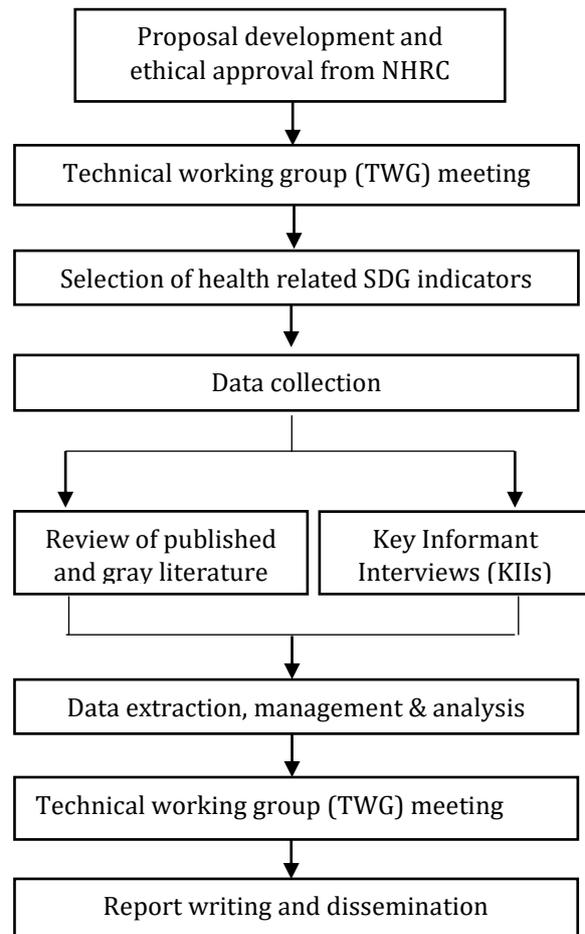
Quantitative part

We did a secondary review of the existing evidence available to understand the status and progress of the selected SDG health related indicators in Nepal. The list of indicators to include in the study was finalized upon consultation from the members of technical working group (TWG) (Annex I). We included all the indicators that falls in SDG 3, few indicators from SDG 2 (i.e. malnutrition among children aged below five years) and few indicators relevant to population characteristics. Extensive review of the published and administrative data was carried out to extract data on the status of the selected health related SDG indicators in Nepal and the gaps in evidence. Data extraction was done for the year 2000 to 2018 by exploring potential data sources (both electronic and gray document) and using a pre-structured data extraction template in Microsoft excel (version 2013). The major data sources included-

- Annual report of Department of Health Services, Nepal
- Nepal Demographic Health Survey
- Multiple Indicator Classification Survey, Nepal
- STEPS survey
- National Census
- WHO database
- UN database
- Institute for Health Metrics and Evaluation database
- World bank database

Qualitative part

For the qualitative part, key personnel involved in health care program planning, implementation, and monitoring the progress were interviewed following the principle of key informant interview (KII) method. A guideline was developed with consultation from the TWG members. The KIIs broadly focused on four key issues- (i) progress in health related SDG indicators (ii) gaps in evidence (iii) challenges in attaining health related SDG indicators (iv) opportunities, and way forward in attaining health related indicators in Nepal. We followed the concept of data saturation and a total of 22 KIIs were conducted. Data collection tools is included I Annex: II.



Data management and analysis

Secondary data analysis: Trend analysis was done to understand the pattern in changes of selected health related SDG indicators in Nepal over time. Projections was made using the existing trend to evaluate the progress at national level in attaining the health related SDG targets by the end of year 2025 using R-studio software. Data visualization of the trend in health related SDG indicators targets and observed values was carried out using Microsoft excel (version 2013).

Qualitative data analysis: All KIIs will be transcribed (verbatim) and translated before data analysis. Coding will be done following code book developed for the analysis. Data will be analysed on broad themes and sub-themes to answer the research questions.

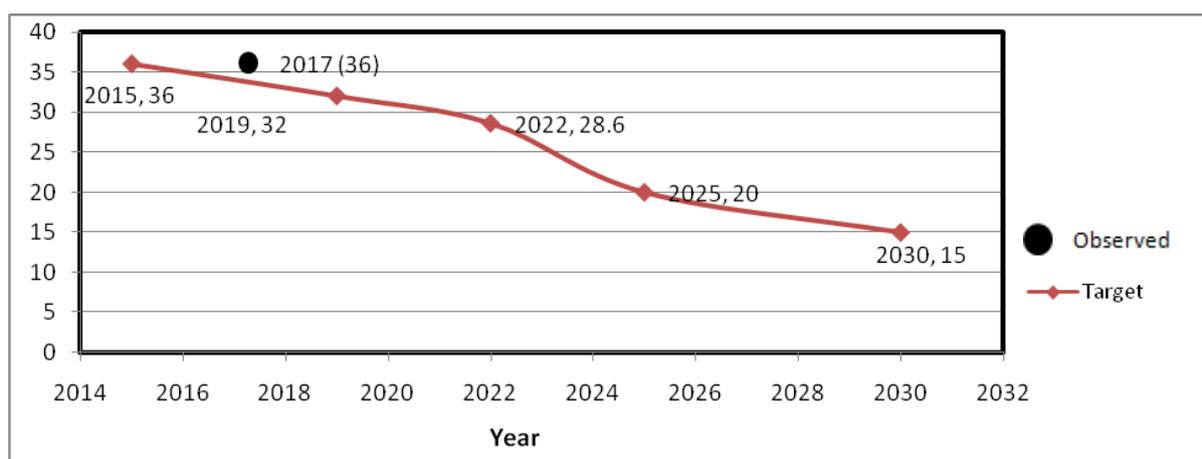
Key Findings

Interpretation of Health Related SDGs Target with Observed Data

SDGs have set country-wise targets against each goal. Although indicators for the health and health-related SDG targets are still at the initial phase, but it is possible to provide an overview of the current situation by comparing target data and available observed data. This comparison will not only provide initial information, but also help to identify the data gaps.

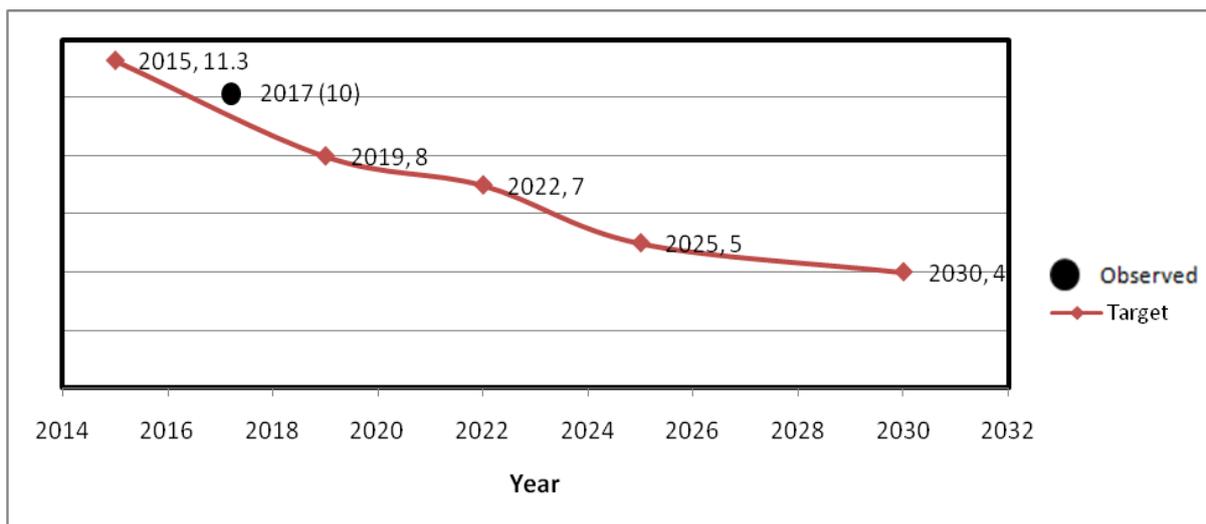
Figure 1 presents prevalence of stunting among children under-5 years of age. The red line indicates target data and the black dot indicates observed data. For this case, there is only one observed data available for 2017. The scatter line for target data shows a gradual decrease starting from 36% in 2015 to 15% in 2030. On the contrary, observed data doesn't likely to comply with the target data. The observed stunting data in 2015 is still the same as 2015 target data.

Unlike stunting, observed data of malnutrition among children under-5 years of age in 2017 seems to comply with the trend of target data. Target data in *Figure 2* shows decrease in percentage of malnutrition from 11.3% in 2015 to 4% by 2030. Observed data seems to have decreased considerably to 10% in 2017 and likely to reach the target set for 2019 (8%).



(Target Data Source: NDHS)

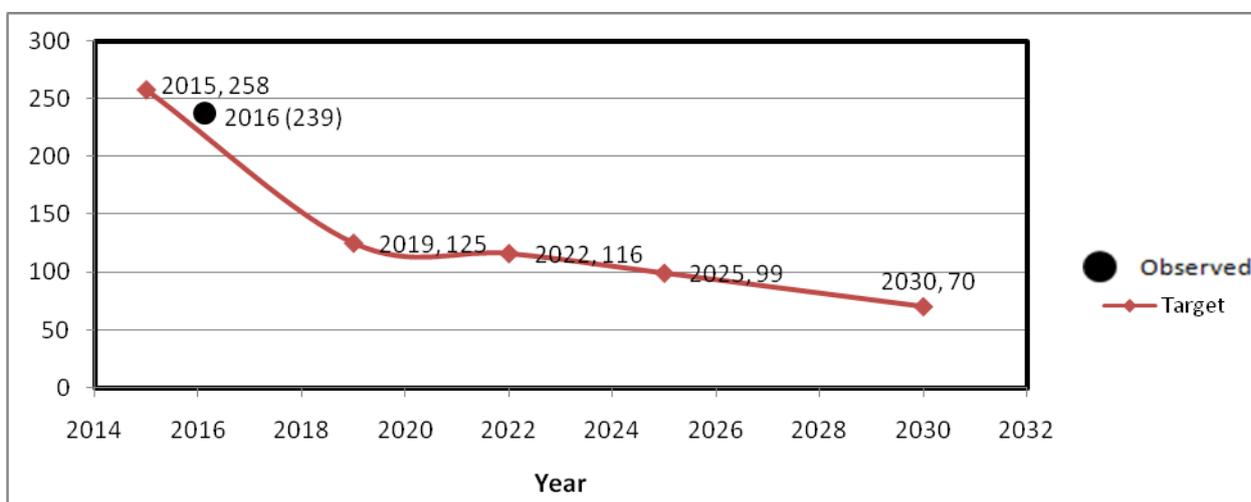
Figure 1 Prevalence of stunting (height for age <-2 standard deviation from the median of the World Health Organization (WHO) Child Growth Standards) among children under 5 years of age (%)



(Target Data Source: NDHS)

Figure 2 Prevalence of malnutrition (weight for height $>+2$ or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting and overweight) (%)

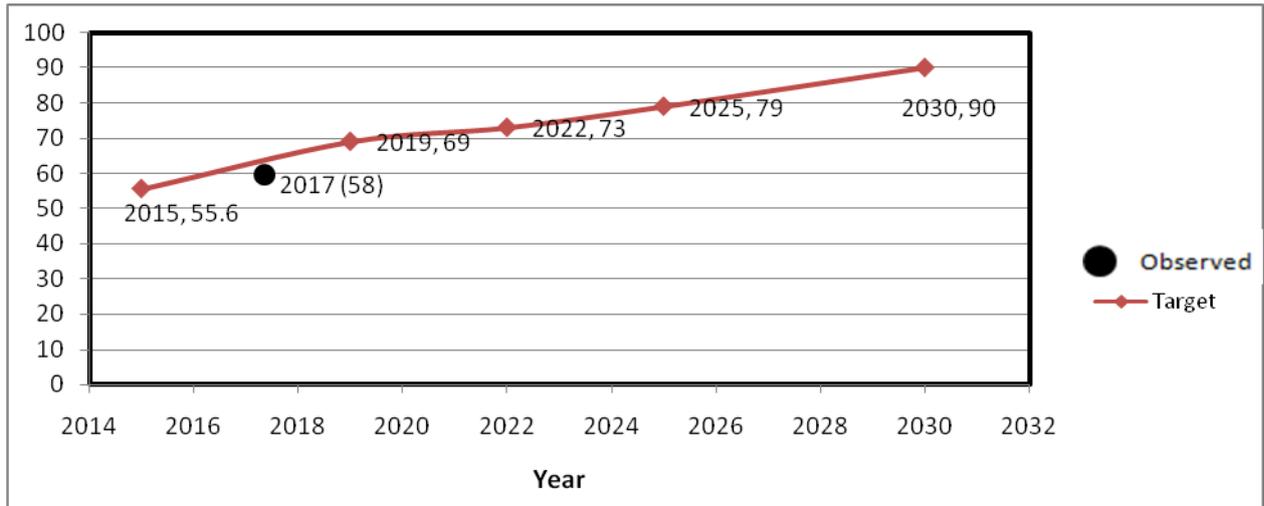
Figure 3 shows SDG targets and available observed data of maternal mortality ratio (per 100,000 live births). Target data shows a rapid decrease from 258 in 2015 to 125 in 2019. After that, it shows a moderate decrease over time. By the end of SDGs, maternal mortality ratio is set to be decreased by 70 (per 100,000 live births). The available observed data of 2016 seems not fully on track considering the targets. It has decreased from 258 to 239 during 2015-2017 time periods, which is not compliant with the targets.



(Observed Data Source: NDHS)

Figure 3 Maternal mortality ratio (per 100,000 live births)

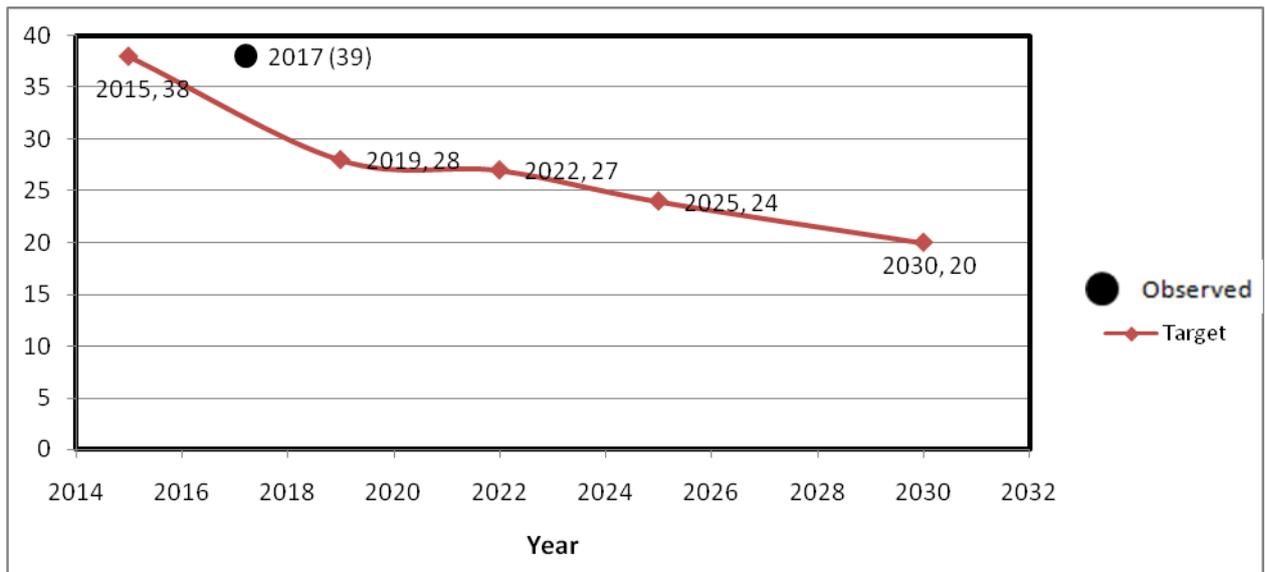
Figure 4 shows SDG targets and available observed data of proportion of births attended by skilled health professionals. Target data shows a consistent increase over the period from 55.6% in 2015 to 90% by 2030. The available observed data of 2017 (58%) seems to be consistent with targets with little short.



(Observed Data Source: NDHS)

Figure 4 Proportion of births attended by skilled health personnel

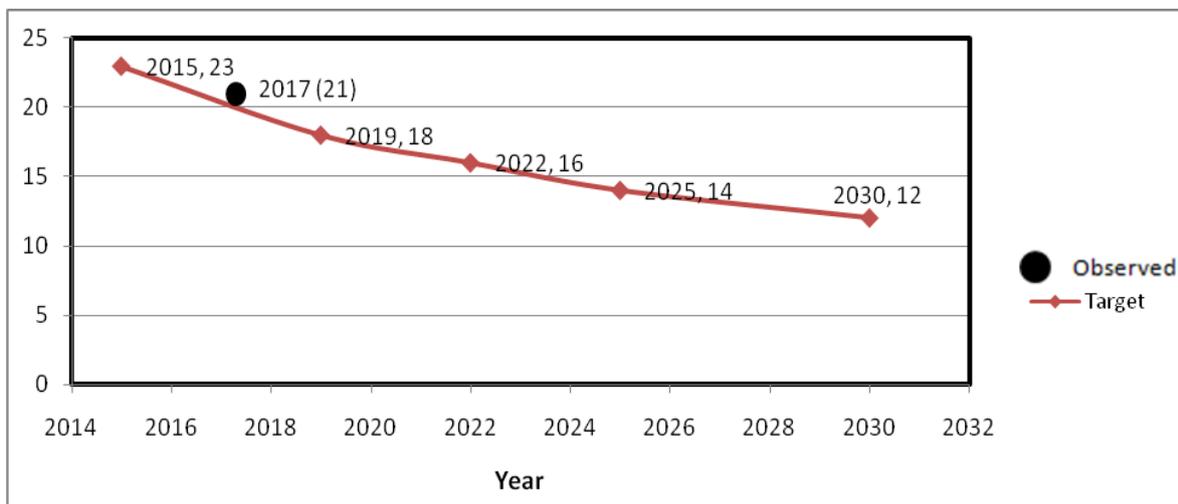
Figure 5 represents SDG targets and available observed data for mortality of children less than 5 years of age (per 1000 live births). Here target data shows a consistent decrease in under-5 mortality from 38 in 2015 to 20 in 2030. The only available observed data from 2017 shows a different scenario. It even increased from 2015.



(Observed Data Source: NDHS)

Figure 5 Under five mortality rate (per 1,000 live births)

Figure 6 represents SDG targets and available observed data for neonatal mortality rate (per 1000 live births). Here target data shows a consistent but slow decrease in neonatal mortality rate from 23 in 2015 to 12 in 2030. The only available observed data from 2017 shows similar type of trend. In 2017, neonatal mortality rate decreased to 21 (per 1000 live births) which is fully compliant with target data.

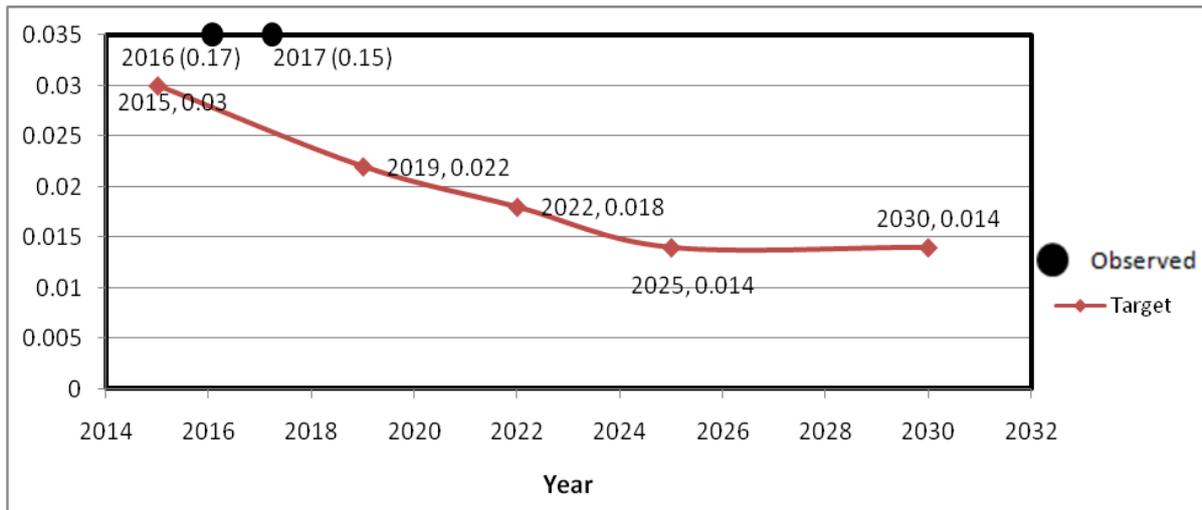


(Observed Data Source: NDHS)

Figure 6 Neonatal mortality rate (per 1,000 live births)

The scatter graph in Figure 7 illustrates information regarding SDG targets and available observed data on number of new HIV infections in every 1000 uninfected

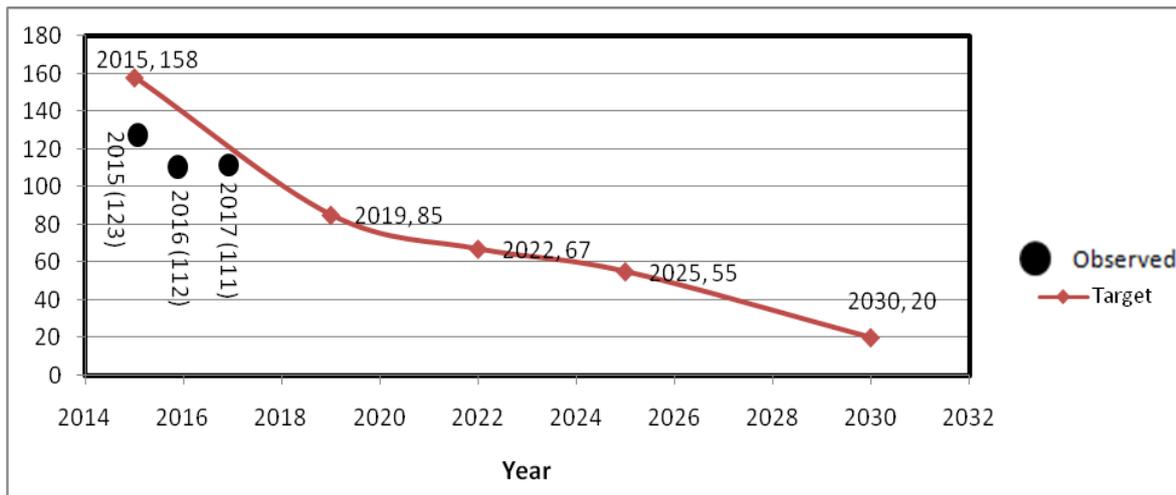
populations within the age range 15-49 years. Target data shows a gradual decrease from 0.03% in 2015 to 0.014% in 2030. From 2025 to 2030, targets data indicates a stable trend with no increase or decrease of new HIV infections. On the contrary, observed data of 2015 and 2016 shows a different trend. There was no decrease of new HIV infections from 2015 to 2016. Besides, the prevalence of new infections (0.1%) seems higher than target data



(Observed Data Source: NCSC)

Figure 7 Number of new HIV infections among adults 15–49 years old (per 1000 uninfected population)

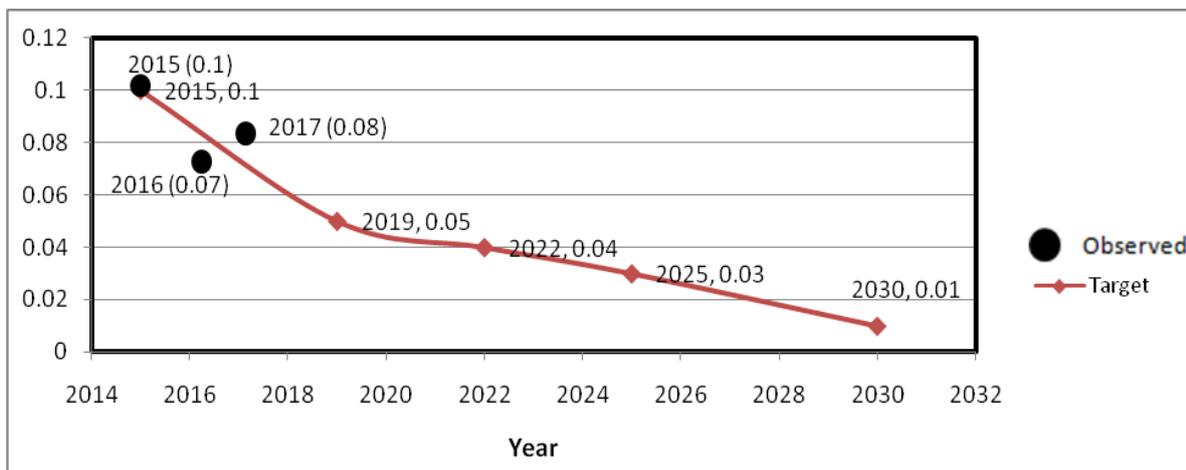
Incidence of tuberculosis (per 100,000 populations) in *Figure 8* shows similar trend to new HIV infection. Here, observed is also non-compliant with target data. Target indicates a rapid decrease of tuberculosis incidence from 158 in 2015 to only 85 in 2019 and a gradual but slow decrease from 2019 to 20 by 2030. On the other hand, observed data from 2015, 2016 and 2017 indicate very little changes in tuberculosis incidence. Within this three-year period, incidence has been decreased by only 4 (per 100,000 populations) with yearly decrease of only 2.



[Observed Data Source: NTC (TB Case Notification rate)]

Figure 8 Tuberculosis incidence (per 100,000 populations)

Figure 9 illustrates target data and observed data for malaria incidence (per 1000 populations). Observed data indicates a consistent decrease from 0.1 in 2015 to 0.01 in 2030. Observed data from 2015, 2016 and 2017 also show a similar trend with target data. This is to mention that, observed data was similar to target data during 2015.

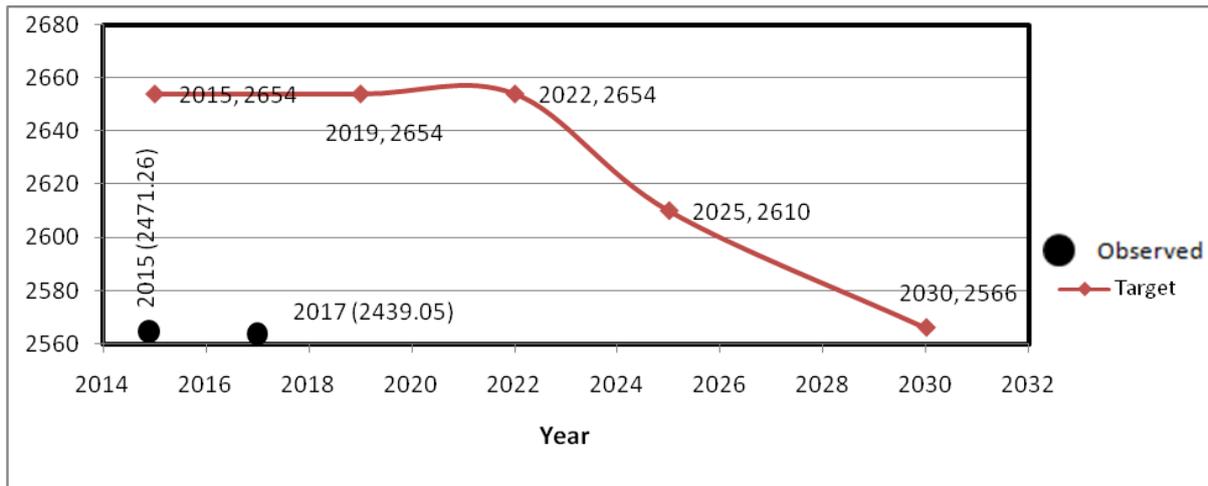


(Observed Data Source: HMIS)

Figure 9 Malaria incidence (per 1,000 populations)

SDGs target data and observed data for Hepatitis B prevalence (per 100,000 populations) has been shown in Figure 10. Here target data represents a plateau

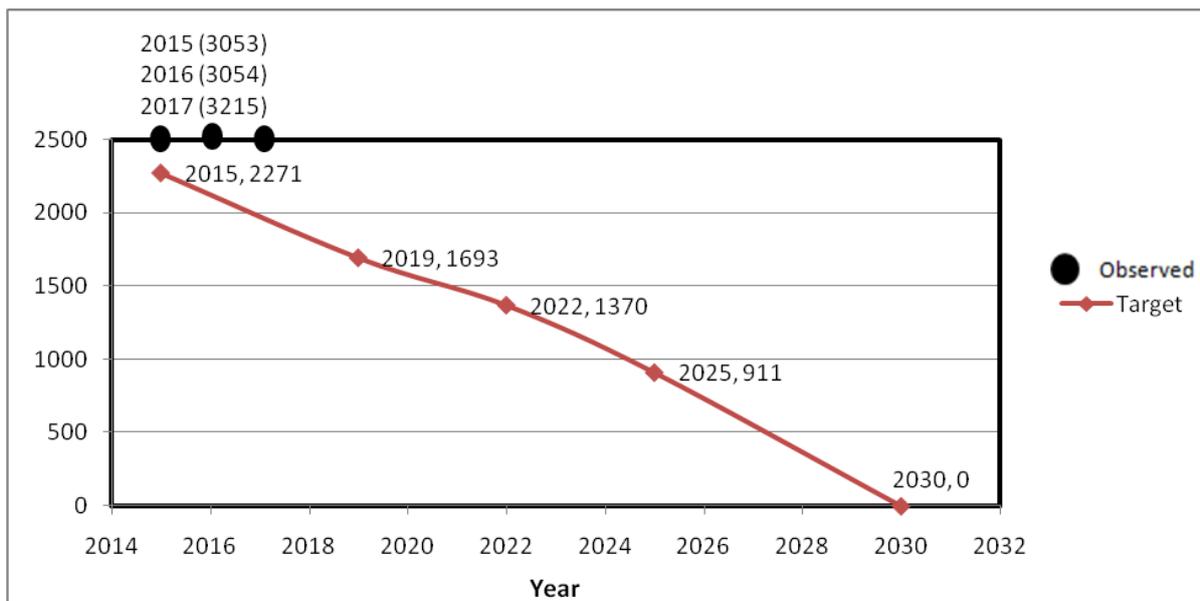
trend from 2015 till 2022. After that target data indicates a gradual decrease from 2654 in 2022 to 2566 in 2030. On the other hand, observed data indicates a completely different scenario. Unlike other health related SDGs targets, observed for Hepatitis B prevalence indicates lower prevalence than target data. The prevalence was 2471.26 (per 100,000 populations) in 2015, which decreased to 2439.05 in 2017.



(Observed Data Source: IHME)

Figure 10 Hepatitis B prevalence (per 100,000 population)

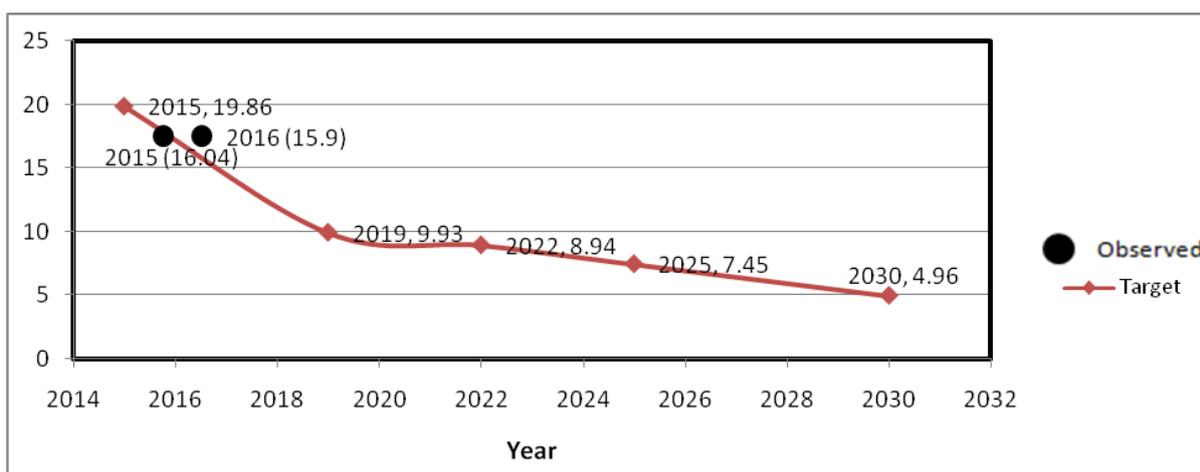
SDGs target data and observed data for leprosy cases has been indicated in Figure 11. Here target data represents a consistent decrease from 22071 in 2015 to 0 by 2030. On the other hand, observed data indicates a different scenario. Although target data displays sharp decrease over the years, observed data seems to be increased (from 3053 in 2015 to 3215 in 2017).



(Observed Data Source: LCD)

Figure 11 Leprosy cases

Figure 12 shows percentage of deaths due to road traffic accidents over the period. The target data decreased sharply from 19.86% in 2015 to 9.93% in 2019. After that, the decrease rate tends to be slow. On the contrary, observed data does not indicate any sharp decrease but a slower one. Death rate decreased by only 0.14% from 2015 to 2016.

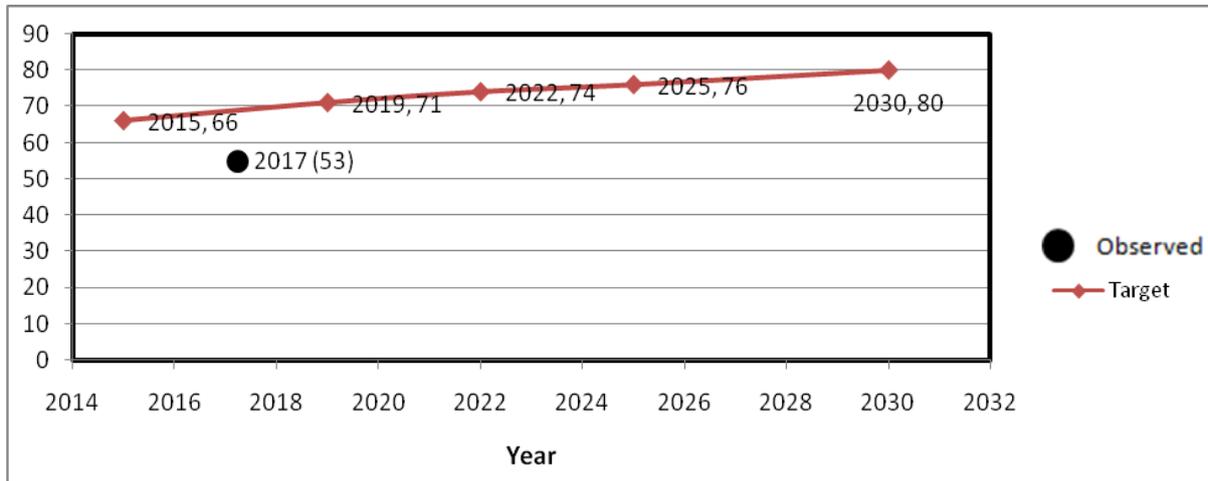


(Observed Data Source: IHME)

Figure 12 Death rate due to road traffic injuries

Figure 13 represents observed and target data for women (aged 15-49 years) of reproductive age who satisfied their need for family planning with modern methods.

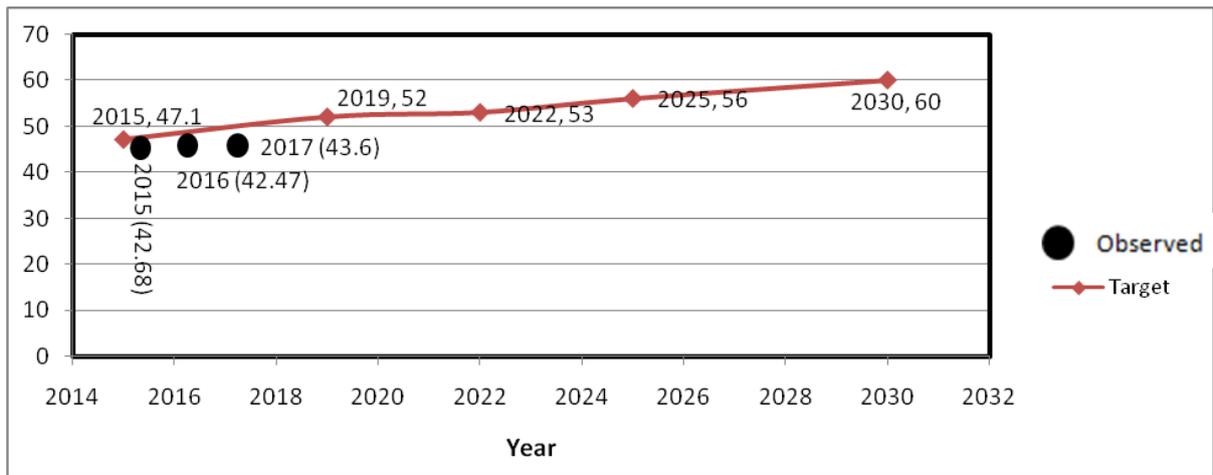
The target data here shows a consistent increase over the period, starting from 66% in 2015 to 80% in 2030. But, observed data seems to be compliant with target data. The only available observed data from 2017 indicates a relatively low percentage (53%) of women aged 15-49 years in their reproductive age who satisfied their need for family planning with modern methods.



(Observed Data Source: NDHS)

Figure 13 Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods

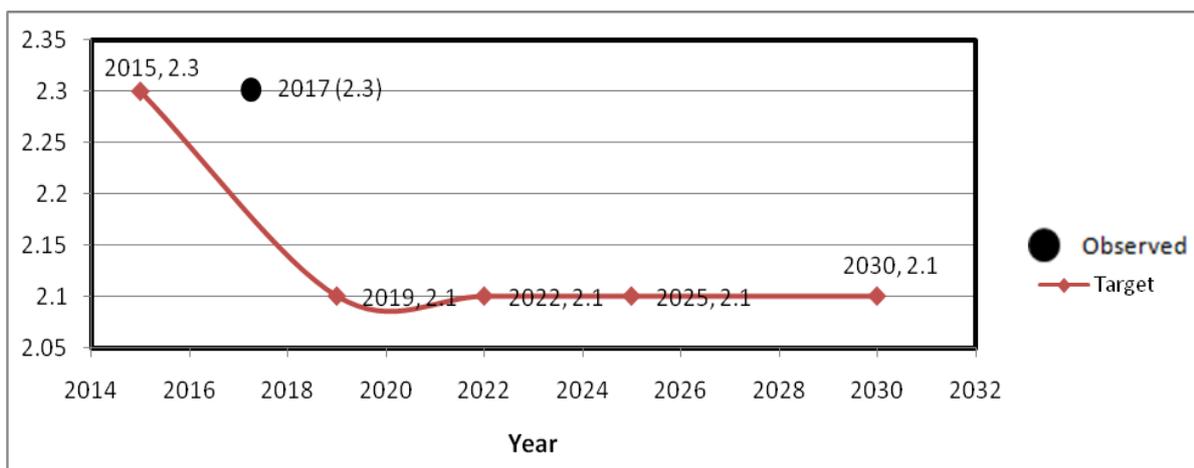
Observed and target data of contraceptive prevalence rate (modern method) has been displayed in Figure 14. Target data indicates a slow but consistent increase in using modern contraceptive methods over the period. During 2015, the target was 47.1%. At the same time, observed data was much lower (42.68%). For the following two years, observed data (42.47% in 2016 and 43.6% in 2017) showed little improvement in terms of using modern contraceptive methods.



(Observed Data Source: HMIS)

Figure 14 Contraceptive prevalence rate (modern methods) (%)

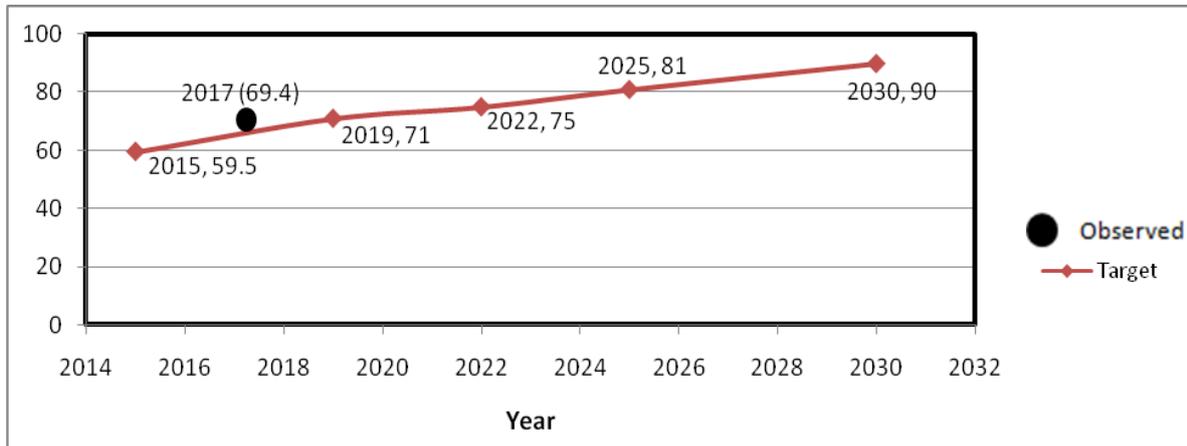
Figure 15 represents observed and target data for total fertility rate (births per woman aged 15-49 years). Target data shows that, fertility rate was 2.3 during 2015 which decreased sharply in the following years and came down to 2.1 in 2019. From 2019 to 2030, it shows a plateau trend (2.1; stable). On the other hand, observed data from 2017 was found same as target data from 2015, which is 2.3. The observed is clearly not compliant with target data.



(Observed Data Source: NDHS)

Figure 15 Total Fertility Rate (TFR) (births per woman aged 15-49 years)

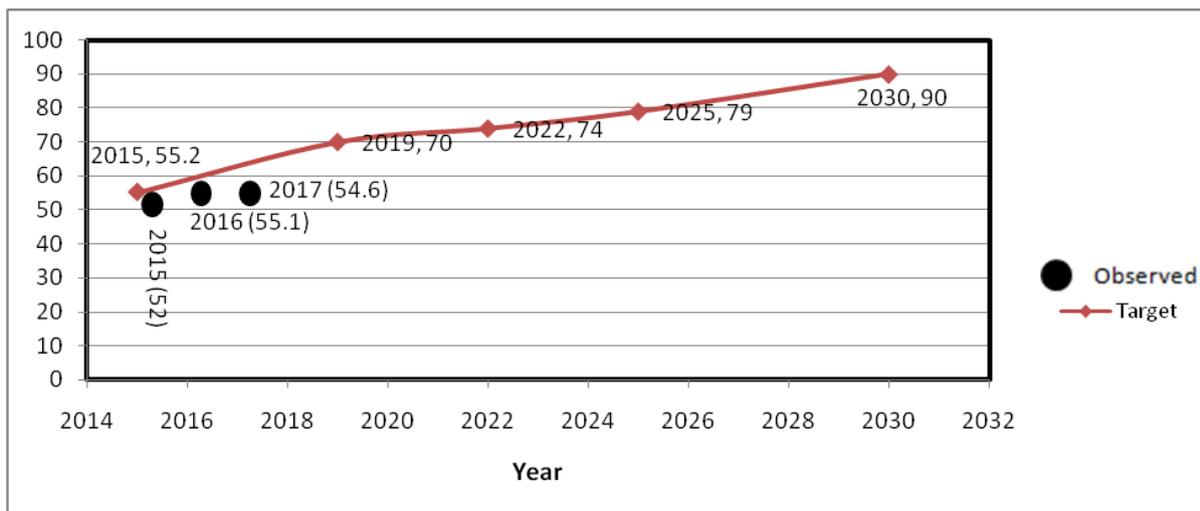
Figure 16 represents percentage of women taking 4 antenatal services (among live births) according to the protocol. Target data shows consistent increase over the periods, starting from 59.5% in 2015 to 90% in 2030. Likewise, observed data from 2017 also shows significant increase of women taking 4 antenatal services by 69.4%. Here, observed data shows to have the increase rate faster than target data.



(Observed Data Source: NDHS; but not according to the protocol)

Figure 16 Percentage of women having 4 antenatal care visits as per protocol (among live births)

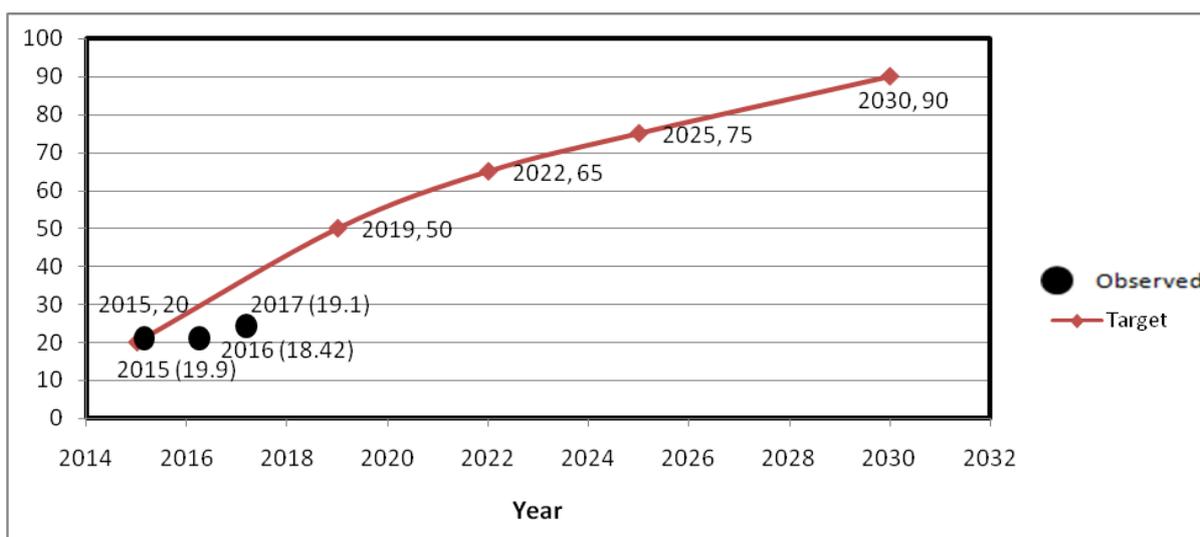
Figure 17 illustrates target and observed data for institutional delivery. Here target data indicates a sharp increase of institutional delivery from 2015 to 2019 (55.2% to 70%) and from 2025 to 2030 (79% to 90%). On the other hand, the interim period shows slow increase. Observed data represents an antithetical status. From 2015 to 2016, institutional delivery increased a little from 52% to 55.1%. After that, it decreased in 2017 by 0.5%. Considering the trend of available observed data from 3 different years, it seems irreconcilable with target data.



(Observed Data Source: HMIS)

Figure 17 Percentage of institutional delivery

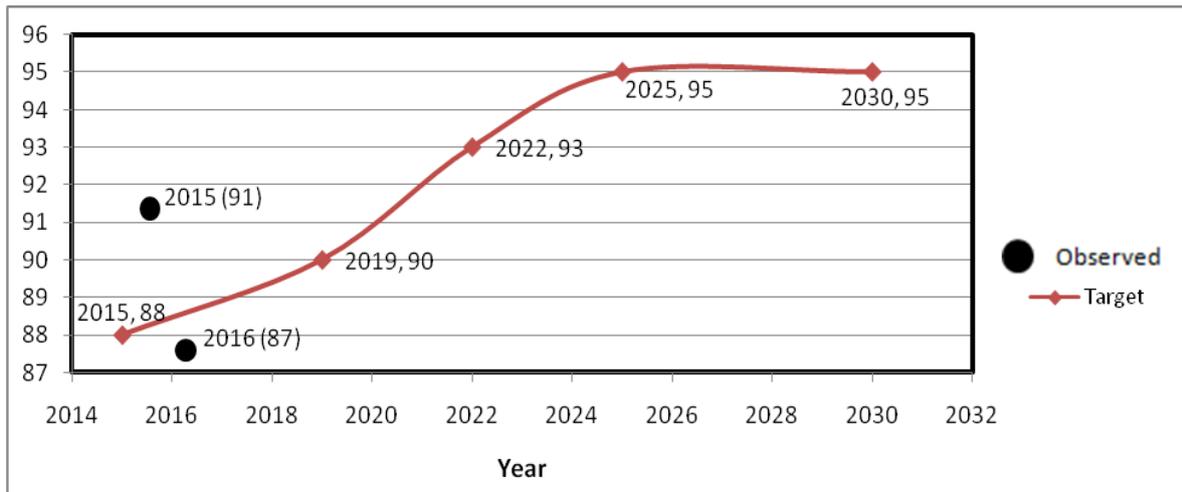
Figure 18 illustrates target and observed data of women attending three PNC as per protocol. Here target data indicates a very sharp increase from 20% in 2015 to 90% in 2030. On the other hand, observed data represents an antithetical status. The percentage of women attending 3 PNC decreased by 0.8% in 2017 as it was in 2015. Considering the trend of available observed data from 3 different years, it seems highly incompatible with target data.



(Observed Data Source: HMIS)

Figure 18 Percentage of women attending three PNC as per protocol

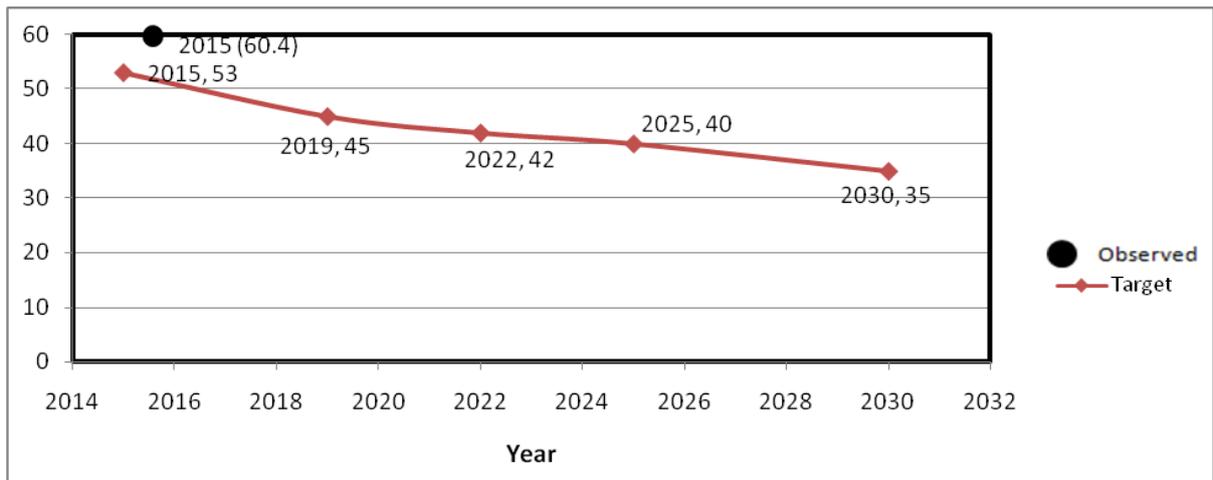
Percentage of infants receiving 3 doses of Hepatitis B vaccine has been displayed in Figure 19. Here target data indicates a consistent increase from 88% in 2015 to 95% in 2025. After that, the percentage seems to remain unchanged till 2030. On the other hand, the observed data for 2015 indicates a higher percentage of infants receiving 3 doses of Hepatitis B vaccine which eventually decreased in 2016. Considering the trend of available observed data from 2 different years, it seems somewhat incompatible with target data.



(Observed Data Source: WHO)

Figure 19 Percentage of infants receiving 3 doses of Hepatitis B vaccine

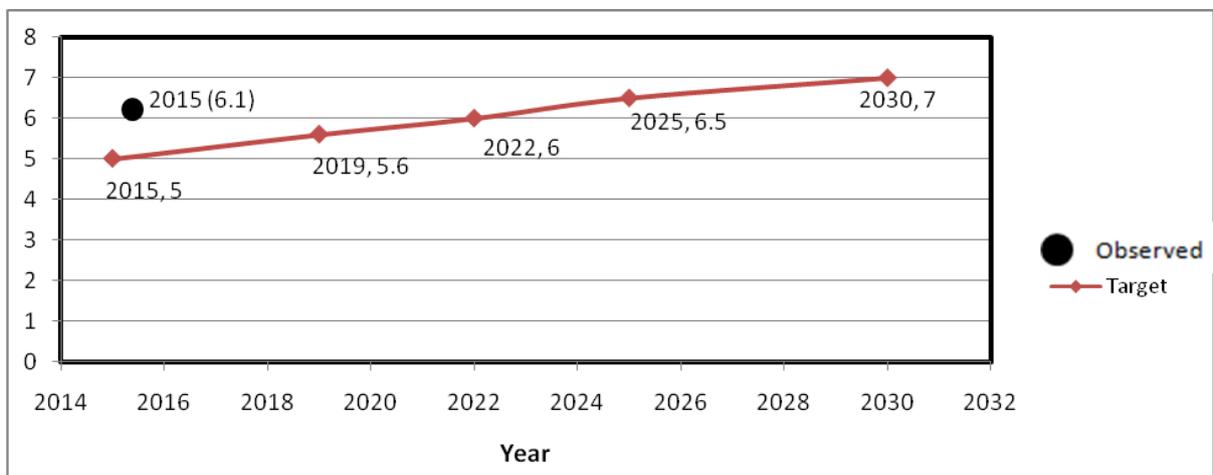
Figure 20 contains information about percentage of out of pocket expenditure in total health expenditure. The target data estimates a gradual decrease from 53% in 2015 to 35% in 2030. On the other hand, there is only one observed data available in this regard from 2015. The observed data of 60.4% out of pocket expenditure among total health expenditure indicates a much higher rate. Although, it's difficult to draw conclusion from a single data, still observed data seems not complaint to target data.



(Observed Data Source: WHO)

Figure 20 Percentage of out of pocket expenditure in total health expenditure

Figure 21 represents percentage of total health expenditure as of GDP. SDGs target estimates a gradual increase from 5% in 2015 to 7% in 2030. But, observed data indicates something different. Data from 2015 indicates 6.1% of total health expenditure as of GDP, which is much higher than of target data from 2022.



(Observed Data Source: WHO)

Figure 21 Total health expenditure as % of GDP

Key Findings

Interpretation of Health Related SDGs Target without Observed Data

Table 1 Targets of Health Related SDGs Indicators without Observed Data

Indicators	Target Data				
	2015	2019	2022	2025	2030
Ending Hunger and Ensure Food Security					
Prevalence of undernourishment	36.1	27.3	20.6	14	3
Nutrition Related					
Percentage of children under age 5 years who are underweight (-2SD)	30.1	20	18	15	9
Prevalence of anemia among women of reproductive age %	35	26	24	18	10
Prevalence of anemia among children under 5 years %	46	33	28	23	10
People requiring interventions against neglected tropical diseases					
Kala-azar (Leishmaniosis) cases	325	203	163	102	0
Lymphatic Filariasis cases	30000	25100	21000	18000	14000
Dengue cases	728	455	364	228	0
Active Trachoma cases	136	85	73	61	49
Percentage of children under age 5 with Diarrhea in the last 2 weeks	12	8	6	4	1
Number of laboratory confirmed cases of Influenza (H1N1)	204	128	113	98	83
Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease					
Mortality between 30 and 70 years of age from Cardiovascular disease,	2.8	2.54	2.35	2.15	1.96

Cancer, Diabetes or Chronic respiratory disease (per 1000 population)					
Cardiovascular disease (per 1000 population)	1.44	1.31	1.21	1.11	1.01
Cancer (per 1000 population)	0.67	0.61	0.56	0.52	0.47
Diabetes (per 1000 population)	0.27	0.25	0.23	0.21	0.19
Chronic respiratory disease (per 1000 population)	0.8	0.73	0.67	0.62	0.56
Suicide mortality rate (per 100,000population)	16.5	14.5	9.7	7.8	4.7
Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol					
Percentage of hard drug users who ever visited Rehabilitation Centers of comprehensive services	40	50	55	60	75
Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in liters of pure alcohol	65				
Percentage of people aged 15 years and older having harmful use of alcohol (define according to the national content)	2	1.9	1.9	1.8	1.8
Ensure universal access to sexual and reproductive health-care services					
Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group	71	56	51	43	30
Achieving universal health coverage					
Percentage of women aged 30-49 years screened for cervical cancer	16.6	36	47	63	90

Percentage of people living with HIV receiving Antiretroviral combination therapy	39.9	90	92	93	95
Percentage of population aged 15 years and above with raised blood pressure who are currently taking medication	11.7	31	39	50	60
Percentage of population aged 15 years and above with raised blood glucose who are currently taking medication	25	33	38	47	60
Percentage of households within 30 minutes travel time to health facility	61.8	69.3	75	80.6	90
Percentage of poor people enrolled in health insurance	0	20	50	75	100
Proportion of population with large household expenditures on health as a share of total household expenditure or income	10.7	7.5	6	4	2
Reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination					
Mortality rate attributed to household and ambient air pollution per 100000 population	111	103.32	98.19	90.51	77.7
Mortality rate attributed to ambient air pollution	64.2	59.76	56.79	52.35	44.94
Mortality rate attributed to household air pollution	64.3	59.85	56.88	52.43	45.01
Mortality rate attributed to unsafe water, sanitation and hand washing (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services) per 100000	37.7	35.09	33.35	30.74	26.39

Mortality rate attributed to unintentional poisoning	0.53	0.49	0.47	0.43	0.37
Tobacco control					
Age-standardized prevalence of current tobacco use among person aged 15 years and older	30.8	26.18	24.33	21.56	15.09
Research and development					
Proportion of the target population covered by all vaccines included in their national program	88	90	95	95	95
Total net official development assistance to medical research and basic health sectors (External Funds for Health as % of Total Health Budget)	12.7	14.5	16	18	20
Percentage of health sector budget for research and development		2	2	3	3
Percentage of government health facilities with no stock out of essential drugs	70	95	95	100	100
Increase health financing and strengthen capacity of countries					
Health worker density and distribution (per 1000 population)	1.05	4.45	4.45	4.45	4.45
International Health Regulations (IHR) capacity and health emergency preparedness	77	82	85	90	95

Table 1 shows target data of various health related SDGs indicators. For these indicators, there is no observed data available so far. Indicators have been organized based on different targets/themes.

In the first theme (*ending hunger, ensure food security and nutritional demand*) which has been discussed in target 2.1 and 2.1; prevalence of undernourishment indicates a consistent rapid decrease from 36.1% in 2015 to only 3% in 2030. Percentage of children under five years, who are underweight, shows a gradual decrease from 3.01% in 2015 to 9% in 2030. At the same time, target data for prevalence of anemia among women of reproductive age has been decreased significantly over the years. During 2015 the prevalence was 35%, which is estimated to be decreased to 10% by 2030. On the other hand, prevalence of anemia among children under five years old has been decreased sharply from 46% in 2015 to 10% in 2030.

The next theme is about *people requiring interventions against neglected tropical diseases* which is described in Target 3.3 (By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases). Here, target data for number of Kala-azar (Leishmaniasis) and Dengue cases is expected to decrease from 325 in 2015 to 0 by 2030. Highest rate of decrease can be seen during 2015-2019 and 2025 to 2030 time period. The interim time period shows comparatively slow but gradual decrease. Similarly, number of Dengue cases is also expected to go down to 0 by 2030 from 723 during 2015. For Lymphatic Filariasis cases and active Trachoma cases, SDGs target data indicates a consistent decrease within 2015 to 2030 time periods from 30000 to 14000 and from 136 to 49 respectively. Active Trachoma cases during 2015 to 2019 showed rapid decrease from 136 to 85. After that, the case shows comparatively slow but consistent decrease. For percentage of children under the age 5 with diarrhea in the last 2 weeks, target data shows a consistent decrease over the years. The percentage was 12% during 2015, which is expected to go down to 1% by 2030. In addition to these, number of laboratory confirmed cases of influenza shows a sharp decrease from 204 in 2015 to 128 in 2019. After that, it shows comparatively slow but consistent decrease and expected to decrease to 83 by 2030.

Issues about mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease have been described in SDG Target 3.4 (By 2030, reduce by one third premature mortality from non-communicable diseases through

prevention and treatment and promote mental health and well-being). Here, target data for Mortality between 30 and 70 years of age from cardiovascular disease, Cancer, Diabetes or chronic respiratory disease (per 1000 population) shows a slow but consistent decrease over the years. During 2015 mortality rate (per 1000 population) was 2.8, which is expected to reach 1.96 by 2030. For mortality rate due to cardiovascular disease and cancer, trend lines show slow but consistent decrease over the years. In case of cardiovascular disease mortality rate (per 1000 population) is expected to decrease from 1.44 in 2015 to 1.01 by 2030. For cancer, mortality rate (per 1000 population) was 0.67 in 2015, which is expected to be decreased to 0.47 by 2030. Target data in terms of mortality rate (per 1000 population) due to diabetes and chronic respiratory disease indicate be decreased from 0.27 in 2015 to 0.19 by 2030 and 0.8 in 2015 to 0.56 by 2030. Lastly, data for suicide mortality rate (per 100,000 populations) indicates a sharp decrease during 2019-2022 and 2025-2030 time periods. During 2015 mortality rate (per 1000 population) was 16.5, which is expected to be decreased to 4.7 by 2030.

SDGs Target 3.5 mentions about *strengthening the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol*. Data for *percentage of hard drug users who ever visited Rehabilitation Centers of comprehensive services* indicate a consistent and gradual increase over the periods from 40% in 2015 to 75% by 2030. For *harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in liters of pure alcohol*, target data is available only of 2015. Data for percentage of people aged 15 years and older having harmful use of alcohol indicates decrease over the periods from 2% in 2015 to 1.8% in 2030. Here, decrease rate is not consistent. From 2025 till 2030 there was no change.

Issues related to ensuring universal access to sexual and reproductive health-care services have been discussed in Target 3.7 (By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs). Under this theme, adolescent (aged 10-14 years; aged 15-19 years) birth rate per 1,000 women has been mentioned in the table. Data shows

that birth rate is expected to decrease by more than half from 71 in 2015 to 30 in 2030. In addition, the trend line seems consistent over the periods.

The next theme is about *achieving universal health coverage* (Target 3.7). Under this theme, the percentage of women (aged 30-49 years) who were screened for cervical cancer increased significantly over the years from 16.6% in 2015, which is expected to increase till 90% by 2030. At the same time period, percentage of people living with HIV receiving antiretroviral combination therapy also increased rapidly from 39.9% in 2015 to 95% in 2030. For this case, the percentage increased so rapidly by 50% from 2015 to 2019. Rest of the time periods indicate a plateau trend. Target data of percentage of population aged 15 years and above with raised blood pressure and blood glucose who are currently taking medication indicate significant upward trend. For both blood pressure and blood glucose, the percentage is anticipated to reach 60% by 2030. During 2015, the percentage was 11.7% and 25% respectively. Percentage of households within 30 minutes' travel time to health facility was 61.8% during 2015 which is expected to go up to 90% by 2030. Percentage of health insurance is also supposed to increase, which one of the significant steps towards achieving universal health coverage. During 2015, there was evidence of health insurance in Nepal. Whereas SDGs target data indicate that by 2030 Nepal will achieve 100% health coverage. On the contrary, target data on proportion of population with large household expenditures on health as a share of total household expenditure or income indicates a reverse trend. The proportion is anticipated to go down to 2% by 2030 from 10.7% in 2015.

SDGs Target 3.8 discusses about *reducing the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination*. Target data shows that, mortality rate attributed to combined household and ambient air pollution (per 100000 populations) was 111 during 2015. This rate is expected to decrease to 77.7 by 2030. Considering their individual status within 2015-2030 time periods, mortality rate attributed to ambient air pollution and household air pollution is anticipated to decrease from 64.2 to 44.94 and from 64.3 to 45.01 respectively. On the other hand, mortality rate (per 100000) attributed to unsafe water, sanitation and hand washing (exposure to unsafe Water, Sanitation and Hygiene for All) indicates a very slow decrease over the periods. SDGs target data predict the decrease rate

from 37.7 in 2015 to 26.39 in 2030. And finally due to unintentional poisoning, morality rate (per 100000) indicates a very slow reduction from 0.53 in 2015 to 0.37 in 2030. For this case, baseline data from 2015 shows very low mortality rate due to unintentional poisoning.

Target 3a discusses about *tobacco control*. Relevant section on target data in the table indicates the prevalence to be decreased to 15.09% by 2030 from 30.8% during 2015. Data also shows a consistent decrease over the periods.

Target 3b emphasizes on research *and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries*. It also highlights provide access to affordable essential medicines and vaccines. Under this theme, proportion of the target population covered by all vaccines included in their national program is anticipated to increase by 7% from 2015 (88%) to 2030 (95%). The data also indicates no visible change from 2022 to 2030. Almost similar percentage of change can be seen for total net official development assistance to medical research and basic health sectors (External Funds for Health as % of Total Health Budget). During 2015 the percentage was 12.7% which is expected to increase till 20% by 2030. Percentage of health sector budget for research and development also reflects the reality of total net official development assistance to medical research and basic health sectors. During 2015, it was only 2% which is supposed to increase by 1% only by 2030. On the other hand, the current stock out of essential drugs in government health facilities indicates significant improvement. It is expected to achieve 100% target by 2030, whereas it was 70% back in 2015.

Target 3c and 3d emphasize *information regarding increasing health financing and strengthen capacity of in developing countries*. Target data indicates that health worker density and distribution (per 1000 population) will increase from 1.05 to 4.45 in 2030. Here, significant change can be seen during 2015 to 2019 time periods. After that, there was no visible change. On the other hand, international Health Regulations (IHR) capacity and health emergency preparedness is anticipated to rise up to 95% by 2030 from 77% during 2015.

Perceived status of health-related SDG in Nepal

Most of the policy makers and program managers were well aware about health related SDG indicators which were directly related with their divisions and sections. The level of understanding was highly varied as some were involved in setting health related indicators and targets and others were just head about these indicators. Some programme managers also raised questions about baseline value of indicators and their sources. It was also raised in the discussion that some targets are ambitious to achieve as baseline are not well defined

Implementation of SDGs in Nepal

The research participants agreed that their ongoing activities have also targeted to SDG indicators and also included in annual work plan and budget. However, some health related indicators which need intersectoral collaboration were not in priority programme of health sector. This demands urgent need of communication and collaboration to address health related indicators such as onroad traffic accident, suicide, mortality etc. Other challenges, faced on implementation of SDGs were limited financial and technical resources, transfer of trained staffs and geographical barriers for providing health services.

Data and Data Gap

Although data sources are clearly mentioned in SDG document prepared by national planning commission, all indicators are not generated or available. All health related SDG indicators are also not included in monitoring and reporting format including in health information management system. However, some policy makers informed that framework for improved management of health information in the context of federal governance structure in Nepal is approved and is being implemented which covers all health related SDG indicators. The data gap and action points is summarized in table 2.

Table 2 Data Gap and Action Point

S.N	Indicator	SDG	Data Gap	Action point
1	Maternal mortality ratio (per 100,000 live births)	3.3.1	No nationally representative data collected on regular basis – NDHS estimates every 10 years National estimates relies on global estimates	Strengthen maternal and perinatal mortality surveillance and response system
2	Under five mortality rate (per 1,000 live births)	3.2.1	XX	
3	Neonatal mortality rate (per 1,000 live births)	3.2.2	XX	
4	Total fertility rate (births per women aged 15–49 years)	3.7.1d	XX	
5	% of children under-5 years who are stunted	2.2.1	XX	
6	Life lost due to road traffic accidents (RTA) per 100,000 population	3.6.1	Nepal Police and Road Department collect data. Not reported to MoH	Collaborate with Road Department and Nepal Police to establish and operate routine MIS and build linkage with MoH
7	Suicide rate per 100,000 population	3.4.2	Nepal Police collects data. Not reported to MoH	Collaborate with Nepal Police to establish and operate routine MIS and build linkage with MoH
8	Incidence of impoverishment due to OOP expenditure in health	3.8.2a	No data to estimate out-of-pocket expenditure for health.	Develop survey plan to meet the data needs and execute
9	Skilled health professional density (per 10 000 population) (doctor, nurse and paramedics ration per 1000 population)	3c.1 (3c.1a, 3c.1b,3c.1c)		

10	% of health facilities with no stock out of tracer drugs	3b.3	xx	
11	% of children fully immunized	3b.1	XX	
12	% of children aged 12-23 months who received DPT3 vaccines	3.8.1d	XX	
13	% of institutional delivery	3.8.1b	XX	
14	Proportion of births attended by skilled health personnel (%)	3.1.2	XX	
15	Antenatal Care (ANC) coverage (at least four visits) (%)	3.8.1a	NDHS gives the information for at least four visits but does not give the data for 4 ANC visit as per (MoH) protocol. National surveys don't disseminate the information.	Further analysis will be made of MICS/NDHS data to generate this
16	% of women attending three PNC as per protocol	3.8.1c	XX	
17	% of demand satisfied for family planning	3.7.1a	XX	
18	Unmet need for family planning (%)	3.7.1b	XX	
19	Contraceptive prevalence rate (modern methods) (%)	3.7.1c	XX	
20	Adolescent birth rate (per 1000 women aged 15–19 years)	3.7.2	XX	
21	HIV prevalence for the overall population aged 15-49 years (%)	3.3.1b	XX	
22	Number of new HIV infections per 1,000 population	3.3.1a	XX	
23	Proportion of people living with HIV receiving Antiretroviral combination therapy (%)	3.8.1h	XX	
24	% of households within 30 minutes travel time to health facility	3.8.1k	XX	
25	Number of laboratory confirmed cases of	3.3.7	XX	Upgrade HMIS to improve

	Influenza (H1N1)			coverage and quality
26	Hepatitis B incidence per 100,000 population	3.3.4	XX	
27	TB incidence (per 100 000 population)	3.3.2	XX	
28	Tuberculosis treatment success rate	3.3.1g	XX	
29	Malaria incidence (per 1000 population)	3.3.3	XX	
30	Prevalence rate (per 10,000 of population) of leprosy	3.3.5a	XX	
31	Total number of Kala-azar (Leishmaniasis) cases	3.3.5b	XX	
32	Average prevalence of Lymphatic Filariasis (%)	3.3.5c	XX	
33	Number of cases of Dengue	3.3.5d	XX	
34	Number of active Trachoma cases	3.3.5e	XX	
35	Average prevalence of Soil Transmitted Helminthes among children aged 5 to 14 years (%)	3.3.5f	No national level data on regular basis	Develop a survey plan to generate this and execute
36	Government health expenditure as percentage of GDP	3c.2	XX	
37	Incidence of catastrophic health expenditure	3.8.2b	Do not have analysis to generate the indicator	Further analysis of NLSS
38	% of OOP expenditure in total health expenditure	3.8.2c	To measure this indicator requires household out-of-pocket expenditure for health and total household income for specific reference periods. A population based survey including measuring questions for standard measurement is required.	Analyze NLSS 2011 data for baseline; and ensure appropriate source for 2020

39	% of ultra -poor people enrolled in health insurance	3.8.11	Health insurance program is just introducing phase. Not available the sufficient to generate this	Support for national coverage surveys to generate the information
40	Mortality rate attributed to ambient air pollution	3.9.1a	No basic information to estimate these indicators	Strengthen sources of information to generate the data in consultation with MoH
41	Mortality rate attributed to household air pollution	3.9.1b		
42	Mortality rate attributed to exposure to unsafe WASH services (per 100 000 population)	3.9.2		
43	Mortality rate attributed to unintentional poisoning (per 100 000 population)	3.9.3		
44	Mortality rate between ages 30 and 70 from Cirrhosis (per 1000)	3.4.3		
45	Prevalence of diarrheal diseases among children under five years (%)	3.3.6	XX	
46	Prevalence of wasting in children under 5(%)	2.2.2a	XX	
47	Prevalence of overweight in children under5 (%)	2.2.2b	XX	
48	Prevalence of anemia among children under 5	2.2.2d	XX	
49	Prevalence of anemia among women of reproductive age (15- 49 years)	2.2.2c	XX	
50	% of people aged 15–69 years who are obese (BMI >=30)	2.2.2e	Population based surveys do not disseminate BMI related information for all people aged 15- 69	Further analysis of NDHS/Micronutrient survey data
51	Proportion of children aged 6-23 months who consume Minimum Acceptable Diet	2.2.2f	XX	

	(MAD)			
52	Proportion of population aged 15 years and above with raised blood pressure who are currently taking medication	3.8.1i	Do not analyse the existing data to generate this information as per required disaggregation	Further analysis of NDHS2016 data
53	Proportion of population aged 15 years and above with raised blood glucose who are currently taking medication	3.8.1j		
54	Age-standardized prevalence of current tobacco use among persons aged 15 -69 years	3a.1		
55	% of people who received pharmacological treatment for substance use disorders among the estimated target population	3.5.1a	No information system to generate it	Update the HMIS system to generate the information
56	DALYs attributed to Mental and substance abuse disorders (per 100000 population)	3.4.4	Data from the service providers/facilities not reported to MoH	Establish and operationalize systems in collaboration with the stakeholders
57	% of people who received psychosocial treatment for substance use disorders among the estimated target population	3.5.1b		
58	% of people who received rehabilitation and aftercare services for substance use disorders among the estimated target population	3.5.1c		
59	Harmful use of alcohol (defined according to the national context) among people aged 15-69 years (%)	3.5.2		
60	Number of hard drug users	3.5.3		
61	Prevalence of uterine prolapsed among women of reproductive age (15-49 years) who ever gave birth	3.8.1e	National surveys do not cover the information G	Generate the information through national surveys

62	Proportion of women aged 30-49 years screened for cervical cancer	3.8.1f		
63	% of designated hub hospitals with response readiness to manage mass casualty events and severe disease outbreaks	3d.1b	Lack of data to generate the indicators	Support EDCD to generate this data routinely
64	Percentage of health sector budget for research and development	3b.2a	Don't generate the information for the indicator in a schedule	Support to NHRC and MoH to develop a system to generate it
65	Percentage of ODA spent in health system research & development	3b.2b		
66	IHR Core Capacity Index	3d.1a	No IHR Core capacity Index developed as recommended by WHO	Develop IHR Core capacity Index as recommended by WHO

Source: Updated from Framework for improved management of health information in the context of federal government structures in Nepal

Ways forward

The health related SDG indicators and targets need to be discussed and reviewed regularly so that it provides timely feedback for tracking progress and identifying gaps. The sources of some health related indicators are national surveys but these surveys timings and SDG related indicators target reporting timeline is different which need to be harmonized. To achieve health related indicators intersectoral collaboration is must and Ministry of Health and Population should take a lead role to achieve these indicators targets. Finally, there should be more regular research studies targeting health related SDG indicators.

References

1. Transforming our world: the 2030 Agenda for Sustainable Development: Sustainable Development Knowledge Platform.
2. United Nations. The Future We Want: Sustainable Development Knowledge Platform. (Sixty-sixth session, Agenda item 19). Report No.: A /RES/66/288.
3. World Economic Forum. How the SDGS can help address global health challenges?
4. Hill PS, Buse K, Brolan CE, Ooms G. How can health remain central post-2015 in a sustainable development paradigm? *Globalization and Health*. 2014 Apr 3;10(1):18.
5. World Health Organization. Positioning Health in the Post-2015 Development Agenda. WHO discussion paper. 1–4 October 2012 - Google Search.
6. WHO (2016), Provisional agenda item 13, SUSTAINABLE DEVELOPMENT GOALS, http://www.wpro.who.int/about/regional_committee/67/documents/wpr_rc67_8_sdgs.pdf - Google Search.
7. National Planning Commission, 2016: The Millennium Development Goals, Final Status Report, 2000–2015. Government of Nepal, National Planning Commission, Kathmandu, Nepal - Google Search.
8. Lee J. How Can We Track Progress on the SDGs? Here's How. unfoundation.org. 2018.
9. National Planning Commission G of N National Planning Commission, Kathmandu, Nepal. Sustainable Development Goals, 2016-2030, National (Preliminary) Report. 2015.
10. National Planning Commission, 2017: Nepal's Sustainable Development Goals, Baseline Report, 2017. Government of Nepal, National Planning Commission, Kathmandu, Nepal - Google Search.

11. Sustainable Development Solutions Framework, 2015, Indicators and a Monitoring Framework for the Sustainable Development Goals: Launching a data revolution for the SDGs, A report by the Leadership Council of the Sustainable Development Solutions Network, - Google Search.
12. Donald K, Way S-A. Accountability for the Sustainable Development Goals: A Lost Opportunity? *Ethics & International Affairs*. 2016;30(2):201–13.
13. OIOS Support to the Follow-up and Review of the SDGs: an Advisory. United Nations Office of Internal Oversight Services Inspection and Evaluation Division (OIOS-IED); 2017.

Annex I

List of TWG members

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Annex II Data Collection Tool

Nepal Health Research Council
Ramshah Path, Kathmandu

SDG Indicators in Nepal: Assessing Progress, Challenges and Opportunities Guideline for Key Informant Interview (KII)

Instruction for Interviewer

- The tool is designed to obtain information from policymakers about SDG related indicators and their overall status in Nepal. The information available from the interview is an important component of the study to validate the results achieved from the secondary analysis of SDGs data.
- The entire interview is structure around four broad discussion areas and the concluding questions. The intended interview duration is around 45 minutes to an hour.
- Interviewers are required to follow the information/instruction indicated in the parenthesis to facilitate the discussion.
- Interviewers are encouraged to supplement the audio recording with a interview note ass detail and comprehensive as possible.

Opening Questions

1. Please greet the participant, explain the purpose of the interview in relation to the study objective. Explain the expected role of participant in the interview, obtain informed consent and proceed for the Discussion Theme #1.

Discussion Theme #1: Perceived status of health-related SDG in Nepal

1. Based on your experience and scope of work, what is the status of SDG indicators in Nepal?

(Please provide a SDGs factsheet to the participants and provide a few minutes for them to reflect on the SDGs indicators. SDGs factsheet is a page document that summarises SDGs indicators, baseline and targets in a tabular form.)

2. Which specific SDGs indicator(s) is directly and indirectly fall within the scope of your department/unit? ***(Please guide the participant to identify specific SDGs indicators from the factsheet)***
3. What different type of problems related to SDGs you and your department/unit are aware of , know, have seen r have experienced? ***(Please encourage participants to express their views within the scope of SDGs indicator that their department/unit is directly and indirectly related)***

Discussion Theme #2: Implementation of SDGs in Nepal

1. What are the program and activities that your department or unit are conducting to support the achievement of SDGs
 - How do you align the SDG indicators in the annual plan of your department?
2. Who are the major implementing partners for this program and how the activities are being coordinated?
 - How the local bodies are being included in this implementation process (as implementing partners)?
3. What are the implementation challenges (*for example. service delivery, human resource, financing, logistic supplies including medicine, leadership/governance*) and what are the opportunities to overcome these challenges?

Discussion Theme #3: Data and Data Gap

1. What is the monitoring and reporting system in your department?
2. How the existing monitoring and reporting system of your department is helping the monitoring of SDG indicators? (***Please probe for some examples of indicators that they are reporting to generate evidence of the SDG status***)
3. Do you think these are enough to monitor the status of the SDG indicators related to your department? (***Please probe for existing data gap in relation to SDGs based on what theory are collecting and reporting***)
4. What are the challenges that you (and your department/unit) are facing in reporting the SDG related indicators? What are ways to improve the monitoring and reporting system to capture the data related to SDGs indicators?

Discussion Theme #4: Ways forward

1. What is needed to achieve the overall health related SDG indicators in Nepal? (Please probe for specific roles and responsibility of the participants. and his/her department/unit, in achieving the SDGs indicators)

Concluding Questions

1. Is there anything you feel are missing or would like to talk about topic we have discussed today?
2. Do you have any queries about this study or the topic that we discussed today?

(Please draw the conclusion of the interview by highlighting the major points emerged in the discussion and express a note of thanks for the participants' time and contribution)