Original Article *Journal of Multidisciplinary Research Advancements (JOMRA), Vol. 3, No. 2 (2025), 208 – 217*
e-ISSN 2990-7721 Available online at https://www.nepjol.info/index.php/jomra

Building Resilience in a Federal System: A Performance Audit of Nepal's Progress Towards SDG Target on National Public Health Emergency Preparedness

Namuna Pandey

Office of the Auditor General, Nepal

Corresponding author: pandeynamuna@gmail.com

Abstract: Sustainable Development Goal (SDG) Target 3.d focuses on measuring a country's strengthening of self-contained early warning, risk assessment and management, and health risk reduction through core International Health Regulations (IHR). IHR is an instrument of international law, adopted pursuant to Article 21 of the World Health Organisation (WHO) Constitution, and is legally binding on 196 States Parties, including all 194 Member States of WHO. This paper examines how Nepal endeavours to achieve this target in the context of the country's transition to a federal governance system. A performance audit was conducted, utilising data from secondary sources (2016 onwards), including government publications, reports from international agencies, and peer-reviewed academic articles. A specific case study on the response to COVID-19 was included. Analysis was conducted in accordance with the International Organisation of Supreme Audit Institutions (INTOSAI) guidelines for self-contained report evaluations, focusing on possible divergence and convergence, the Leave No One Behind (LNOB) principles, cross-domain considerations, and structural finance. Progress is undermined by a controlled information vacuum. Since the last IHR was issued in 2015, the country has been in a state of stagnation, albeit self-sustaining. Although the country has a constitutional basis for health, policy and implementation levels are characterised by widespread vertical and horizontal misunderstandings among federal, provincial, and local governments. The COVID-19 response relegated the issue of 'proliferated temporary control mechanisms' or missing rational command systems. Financial analysis showed what appeared to be "firefighting" models, which allocated declining investments to the core preparedness functions like epidemic control, which fell to 2% of the federal health budget in 2021/22, and spending for COVID-19 emergencies, which constituted 36% of the federal health budget in 2021/22. The overarching Target 3.d monitoring and evaluation mechanisms were weak and lacked specified operations for subnational units. The systemic governance and financing issues inherent to transition federalism, which are inescapable for Nepal, pose acute challenges to achieving SDG Target 3.d by 2030. Scaling the governance system while strengthening IHR financing and core systems, and monitoring discretion through proactive mechanisms, is imperative for the resilience of the National Public Health System.

Keywords: *SDG, Health System Resilience, performance audit, federalism, Nepal, Public Health Emergency, Disaster Risk Management*

Conflicts of interest: None
Supporting agencies: None

Received 9.11.2025 Revised 5.12.2025 Accepted 22.12.2025

Cite This Article: Pandey, N. (2025). Building Resilience in a Federal System: A Performance Audit of Nepal's Progress Towards SDG Target on National Public Health Emergency Preparedness. *Journal of Multidisciplinary Research Advancements*, 3(2), 208-217.

1. Introduction

The Sustainable Development Goals (SDGs) were established through the adoption of the 2030 Agenda, which included a commitment to greater equality and enhanced sustainability as central goals for the future (Raszkowski & Bartniczak, 2019). Of these goals, SDG 3 sets out to "ensure healthy lives and promote well-being for all at all ages. One crucial aspect of the goal is target 3.d, which, within developing countries, strengthens the capacity of all countries to undertake the early warning, risk reduction and management of national and global health emergencies and other health issues (Srivastava & Khan, 2024). This is achieved through Indicator 3.d.1, which states, "International health regulations (IHR) capacity and

health emergency preparedness," thus, the proximity of national public health resilience to the WHO (2005) IHR framework is established.

Nepal, as a signatory to the IHR (2005) and a member state of the WHO, is obligated to develop surveillance, core reporting, and response capacities, as well as public health threat response capabilities (World Health Organization, 2023). This is also shown in the country's planning documents, such as the 25-year Vision and the Fifteenth Periodic Plan, which aim to attain the SDGs by 2030 (NPC, 2024). Nevertheless, the shift to a federal system of governance in 2015 has, in decentralizing the country's governance, also introduced new complexities in policy congruence and institutional coordination, as well as fiscal management, at the federal, provincial and local governance levels. This, alongside the SDG implementation period, both creates and complicates the environment in which integrated public health goals are to be achieved.

Global public health emergencies, the latest being the COVID-19 pandemic, have starkly highlighted the need for a system to support the country's health (Rayamajhee et al., 2021). They illustrate the nation's ability to predict, prevent, and prepare for potential health risks, as well as the ensuing governance, financial, and multi-sectoral gaps. It is the country's geography, economy, and society that give great significance to the need for a system ready to bear shocks, such as the one envisioned with SDG 3.d. In Nepal, such a system is a fundamental requirement for both national security and sustainable development (NPC, 2017).

Despite these concerns, thorough primary evaluations of Nepal's progress towards achieving SDG 3.d. are lacking. The Office of the Auditor General, Nepal (OAGN), in cooperation with INTOSAI Development Initiative conducted independent performance audit with the aim to provide the OAGN with relevant answers. This paper is primarily based on the report of the same. It outlines the relative approaches and primary efforts to protect public health, considering the rules of public health systems legislation and their coherence, as well as the setups of governing systems, financing, and primary monitoring. In context outlines of secondary context, dominant sub federal tier of public order legal systems, as well as her dominant direct order to manage the public's health and the best case of COVID-19, system structures and dominant blockages to her lowest primary and current external obligations under SDG 3.d. targets are illuminated.

2. Materials and Methods

This study used a descriptive method and secondary data from 2016 to 2020. As the topic itself indicates, the study needed to rely on the historical data for progress assessment. The scope of SDG target 3d being wide and including a lot of crosscutting issues demanded for a review of already available statistics and documents more than collecting new data. Data from authentic government agencies that are readily available on their websites were chosen being the most economic, efficient and reliable sources of data. As the study was conducted between 2020 and 2022 when the COVID 19 pandemic was at peak, the use of secondary data and sample-based approach was inevitable due to field visit restrictions. Data collection utilized documents acquired from government and intergovernmental agencies, as well as reports from international agencies such as the WHO, along with materials from Non-Governmental Organizations (NGOs) and academic resources. Considering the audit's findings and the public health emergency, it also included a case study on Nepal's approach to the prevention, control, and treatment of COVID-19. However, as the report needed updated information on some issues and also to incorporate some qualitative aspects while confirming the findings of the study, an exit meeting was conducted with the personnel of the Ministry of Health and Population, once the draft was prepared, which provided some insights to be incorporated during the finalization phase.

Although the audit was conducted on a sample basis, it was intended to address issues pertinent to the federal, provincial, and local tiers of government. Furthermore, primary data were also collected through questionnaires and interviews with key informants and relevant stakeholders to complement the secondary data. The analysis was based on the INTOSAI international auditing standards, as well as the Performance Audit Guidelines of the OAGN, in relation to overarching themes of coherence, multi-sectoral engagement, LNOB, and fiscal analysis.

3. Results

Although the audit was conducted on a sample basis, it was intended to address issues pertinent to the federal, provincial, the performance audit on Nepal's undertaking to develop a robust and resilient national public health system, targeting SDG 3.d, contains a wealth of valuable insights. This analysis, within the elements of progress indicators, policies, institutions, system frameworks, finances and monitoring of these frameworks, outlines a broad horizon of dreams with deep-rooted systemic constraints to realization, collaboration, and financing, within federalism at the dawn of its existence.

3.1. Progress Against Target 3.d

Nepal's progress in achieving SDG 3.d and the accompanying metrics has, as in the preceding cases, been fundamentally constrained by the absolute lack of data. Target 3.d has only one indicator, specifically 3.d.1: "International Health

Regulations (IHR) capacity and health emergency preparedness." The most widely recognized method for assessing this ability is the Joint External Evaluation (JEE), which is a participatory and multi-jurisdictional process. Nepal could undergo JEE only in the late 2022 and the report was published by WHO in 2023 which made it impossible to incorporate the outcomes in this study. And hence the only means of assessment that could be considered was "self-report" and States Parties Self-Assessment Annual Report (SPAR). The self-assessment based on SPAR criteria of 2015, also considered as the baseline assessments, yielded a score of 77. In the absence of external verification, the only time-series analysis available in the period of this study was SPAR, which, like all self-reporting mechanisms, is unreliable.

There were analytical challenges associated with the SPAR data itself. The World Health Organization's core capacity indicators have undergone revisions over time, increasing from 13 to 15 in 2021, which has impacted score comparability over the years. Nevertheless, the SPAR data indicated an alarming trend. While the global and South-East Asia regional averages experienced a slight decline from 2015 to 2019, Nepal's score dropped significantly more during this period. The 2021 SPAR demonstrated a remarkable improvement as Nepal's rate of increase during this time was higher than the global and regional averages.

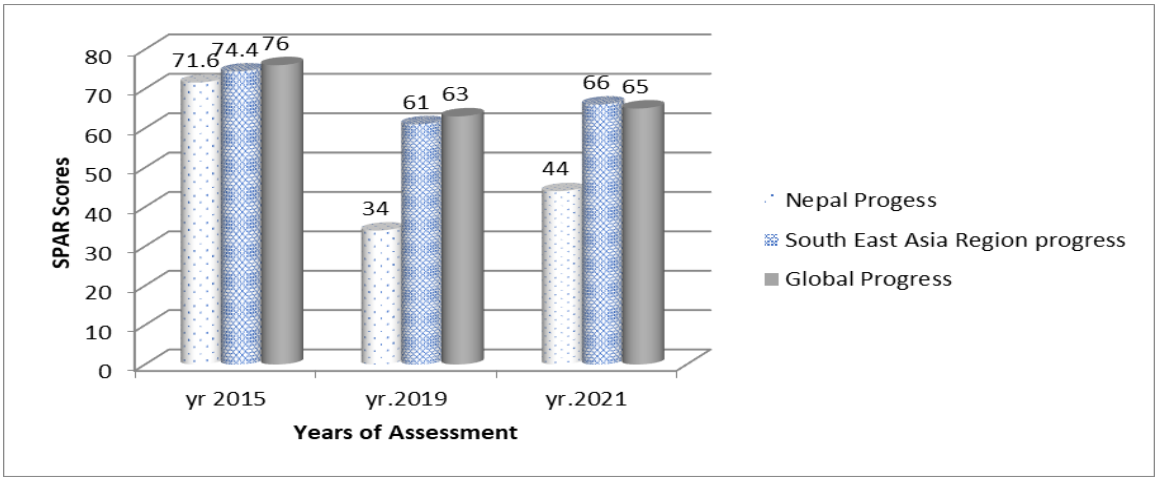

Figure 1: IHR Core Capacity Progress status of Nepal in comparison with southeast Asia Region and Global Progress. (Source: WHO e-SPAR)

While this recent progress was commendable, the study concluded that the absolute score remained "much below the milestones and the ultimate target set" by the National Planning Commission (NPC) in its SDG roadmap. A direct comparison between the SPAR data and the NPC's roadmap illustrated that Nepal was not on track to achieve the 2030 target.

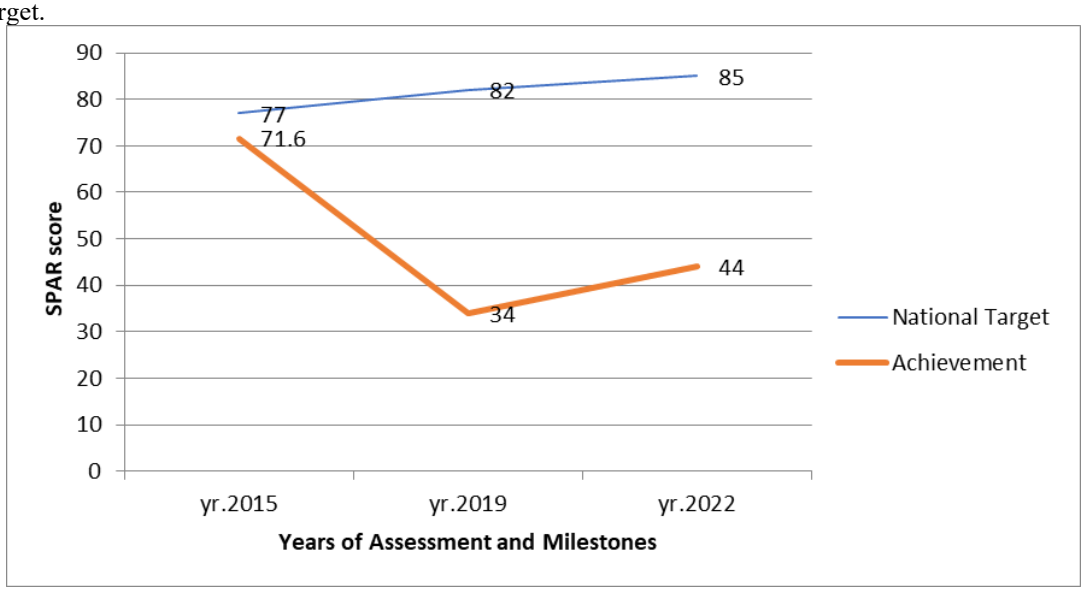

Figure 2: Comparison of IHR capacity progress status of Nepal (based on SPAR) with milestones targeted by the National Planning Commission, Nepal.

The lack of target data and inconsistent progress directly affected how the data was reported on the national level. NPC's progress report from 2016 to 2019 was unable to incorporate data for Target 3.d, and the Voluntary National Reviews (VNRs) suffered from the same limitation. The audit thus pointed out that the country was on a self-assessment of these

crucial targets, without independent and contemporary external evaluation of its primary self-reported and volatile core strengths. This suggests that the self-reported national target was unachievable.

3.2. Policy and Legal Frameworks

The legal and constitutional foundation dedicated to health in Nepal was observed to be strong. The Constitution of Nepal, enacted in 2015, included health as a fundamental right and warrants every citizen the right "to free basic health services from the State" as well as being guaranteed that no one is denied access to emergency medical services. It also provided for the right to health information as well as access to health, hygienic and safe drinking water and sanitation, with the right and special attention to women and children, the poor and excluded, and other vulnerable groups, embracing the principle of Leave No One Behind (LNOB) in the country's Constitution for the first time. At the national level, this was implemented through the National Health Policy, 2019, and the Public Health Service Act.

The audit, however, found a striking deficiency. There was no specific policy, strategy, or guideline dedicated solely to forecasting, prevention, and preparedness for the risk of public health emergencies. The IHR Approach, which is multifaceted and crosscutting, was not developed into a dedicated strategic document. This meant that the functions of SDG Target 3.d were subsumed within a wider cross-health and disaster policy framework, which lacks focus. In addition, the federal structure policy framework was characterized by a lack of coherence.

The Constitution allocated health-related responsibilities to federal, provincial, and local governmental tiers – and thus the federal government had 'exclusive' control over formulating health policy, setting standards, and exercising control over communicable diseases; provincial governments had 'exclusive' control over 'health services' and local governments had 'exclusive' control over 'basic health and sanitation;' and the professions and health insurance areas had 'concurrent' powers. This division led to considerable confusion and a lack of accountability. The Functional Analysis and Assignments (FAA) document and the Local Government Operation Act (LGOA) attempted to clarify and address the issues, but the audit concluded that "it is still a challenge to achieve the national target in this new system." The lack of evidence to support the claim that provinces formulated tailored policies for public health risk preparedness is astonishing. The baseline SDG reports, which listed targets, were also found to be extremely disappointing, particularly in a target responsible for global health governance. This suggests targets were absent that were aligned with the national targets and showcased a considerable lack of autonomy, responsibility, and ownership at sub-national levels.

Table 1: Constitutional provisions regarding the distribution of state power towards the health sector. (Source: 2020 Analysis of FAA and Health Policy)

Level	Description of rights	Related clause/annex
Federal (Exclusive)	Health policy, health services, setting standards, quality and monitoring of the health services, national/specialized service providing hospitals, traditional treatment services, control of communicable diseases	Clause 5 (1) and Annex 5
Province (Exclusive)	Health service	Clause 57 (2) and Annex 6
Federal and Province (Concurrent)	Medical, Ayurveda, Aam chi and the other professionals Insurance operation and management	Clause 57 (3) and Annex 7
Local Level (Exclusive)	Basic health and sanitation	Clause 57 (4) and Annex 8
Federal, Province and Local Level (Concurrent)	Health Registration of personal incidents, birth, death, marriage and statistics	Clause 57 (5) and Annex 9

The audit has identified a significant coherence issue regarding the institutional framework for public health emergencies. While the NPC's SDG roadmap gave the indicator 3.d.1 to the Ministry of Health and Population (MOHP) and the WHO, public health emergency preparedness was 'an inevitable part of disaster risk reduction and management' under the (Ministry of Home Affairs) MOHA. The audit quite rightly suggested that MOHA be added to the list of responsible agencies because, as shown in the overlapping health and disaster management policies — such as the Health Policy (2015) and the National Policy for Disaster Risk Reduction (2018) — and the Disaster Risk Reduction and Management (DRRM) Act (2017) which, although included as a disaster (GoN, 2017), the audit described as 'insufficient to address the issues of COVID-19' and thus, required separate, stand-alone preparedness and response plans. The 'Reaching the Unreached

Strategy (2016-2030)' was drafted to support the LNOB and Universal Health Coverage (UHC) principles, but the audit described as a federal strategy, which 'lacked the perspective of federalism and assigns no role to the sub-national governments,' is a clear sign of the above. The top-down approach in planning severely restricted the ability to address the needs of vulnerable populations.

3.3. Institutional Arrangement

The research study revealed that within Nepal, there are numerous overlapping institutions with the intent of managing health and disaster-related emergencies. Regarding the implementation of the SDGs, there is a High-Level Steering Committee chaired by the Prime Minister and an SDG Implementation and Monitoring Committee, coordinated by the NPC Vice Chair. In addition, there is the Thematic Working Committee. For health-specific threats, the MOHP's Department of Health Services has the Epidemiology and Disease Control Division (EDCD), which is the focal point of the IHR (2005) and also manages Early Warning, Alert and Response System (EWARS). Regarding more generic disasters, the DRRM Act geopolitically defines and structures the country's disaster preparedness and risk reduction at the macro, meso, and micro levels, which include the National Disaster Risk Reduction and Management Authority (NDRRMA) and the country's multiple-tiered Emergency Operation Centers (Nepal et al., 2018).

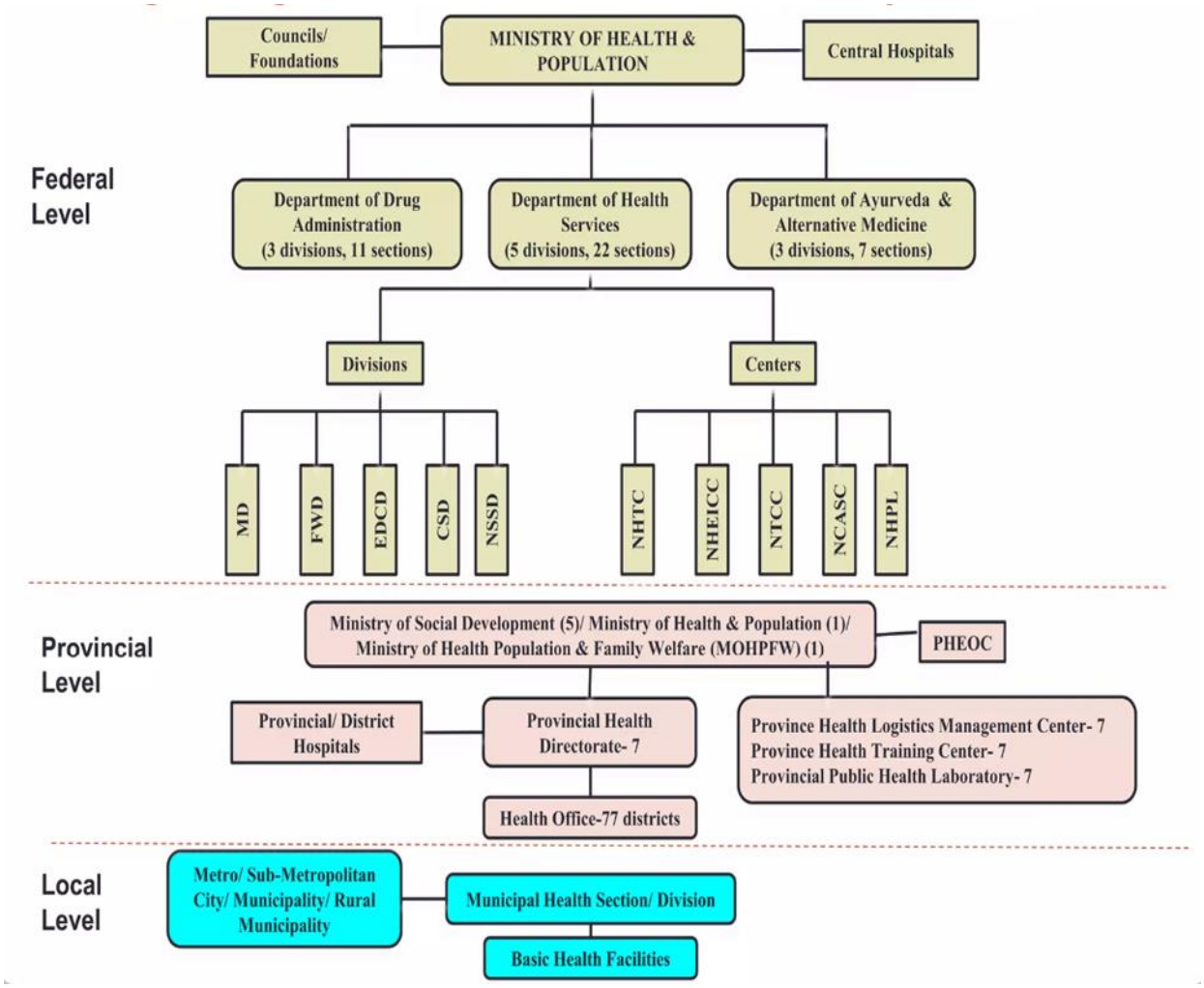

Figure 3: Organogram of the public health service structure of all three levels of government in Nepal.

Despite this seemingly robust institutional map, the audit's central finding was a severe deficit in both vertical and horizontal coherence. The report stated that "although coordination and cooperation between the three levels is essential, no coordination was noticed." This was attributed to the independent nature of each level of government under the new constitution, sometimes leading to "duplication in the operation of public health-related activities." The Health Management Information System (HMIS), a critical tool for surveillance, was updated to the federal structure but suffered from "lack of clarity on, and capacity for, data management," resulting in reporting that was "late, incomplete, poor in quality, or non-existent."

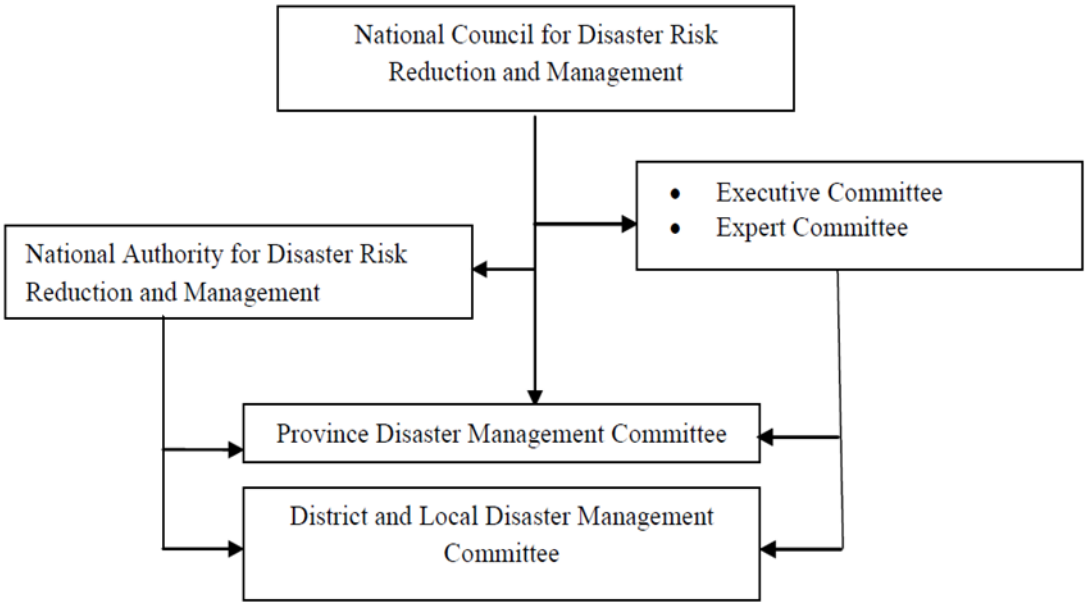

Figure 4: The Disaster Risk Reduction and Management structure of all three levels as prescribed by DRRM Act.

The failure of coordination was evident during the COVID-19 pandemic and served as a valuable lesson. The government established the Temporary COVID-19 Crisis Management Center (CCMC) under the Deputy Prime Minister, despite the existence of permanent structures, such as the Health Emergency Operations Centre and the National Emergency Operations Center. In the words of the audit, "while there are permanent structures established by law, there are also some temporary structures, which increased the number of the agencies… which led to difficulty in the jurisdiction of work and coordination."

These increased coordination problems and work difficulties led to a new command structure that bypassed existing institutions. For example, while the MOHP was the thematic ministry, "it was only after the formation of the High-Level Coordinating Committee and the COVID Crisis Management Center, work was carried out under their direction." This situation resulted in the "one structure did not control or direct another structure", which led to confusion in command and control. The Ministry of Education's blunders, such as late notice of exam postponements and lack of coordination from other ministries, create situations that "resulted in the lack of expected outcomes in the prevention and control of COVID-19."

3.4. Budget and Finance

The analysis of health budgets allocated to all three levels of government during the period FY 2017/18 to 2021/22 revealed a financing pattern that runs counter to the desired outcome of developing a resilient health system (NHSSP, 2022). The audit examined specific economic codes related to public health emergency preparedness, specifically "Communicable, Infectious Disease, & Epidemic Control" and "Laboratory and Diagnostics Services."

The conclusions were disturbing. At the federal level, the budget allocated to epidemic control decreased from 7% of the total health expenditure in 2017/18 to 2% in 2021/22. The budget assigned to laboratory services also remained stagnant at 0.3-0.4%. This persistent contraction in core preparedness investment was a "red flag" indicating that the government was not prioritizing the essential capacities that underpinned effective early warning and risk reduction.

Such a pattern was also evident at the subnational level. At the provincial level, expenditure for epidemic control nosedived from 14% in 2017/18 to 2% in the subsequent years. Laboratory services experienced erratic expenditure patterns, jumping to 15% in a specific year due to targeted COVID-19 responses and then declining to 1% in 2021/22. At the municipal level, the expenditure for epidemic control was capped at 3% of total health expenditure, and laboratory services accounted for a range of 0 to 1%.

Unlike other budget lines, the "COVID-19 response" budget line was primarily defensive in nature. Within the federal health budget, it soared to 36 per cent of the total in 2021/22. Sub-national expenditure accounted for 26 per cent, while local expenditure accounted for 11 per cent. This extreme contrast led the audit to determine that the "firefighting" model was used to determine a response to the crisis. It lacks both the preparedness and the proactive parts of a strategic response. It was designed to allocate money for crises that have already unfolded, rather than preventing the crisis in the first place, or at the very least, making strategic investments to lessen the impact of a potential crisis. This was made worse by the issues around conditional grants and the absence of policy on sub-national health planning, risking a lost "opportunity to realize SDG targets." Of the audit's findings, the absence of chronic underinvestment in fundamental capacities as required

by the IHR and SDG Target 3.d was not offset by improvements made to budget tagging for gender (women's health) and poverty reduction.

Table 2: Percentage Allocation of Health Budget by Federal Government by selected Line Item/Economic Code (Amount in NPR millions)

Economic code	**year 2017.18**		**year 2018.19**		**year 2019.20**		**year 2020.21**		**year 2021.22**	
	Budget	**% of total budget**	**Budget**	**%**	**Budget**	**%**	**Budget**	**%**	**Budget**	**%**
Total Budget	46,866		56,420		68,779		90,690		133,121	
Communicable, Infectious Disease, & Epidemic Control	3,225	7	2,703	5	2,418	3.5	3,705	4	2,957	2
Laboratory and Diagnostic Services	207	0.4	150	0.3	173	0.25	366	0.4	348	0.3
COVID-19 response	0	0	0	0	0	0	6,113	6.7	48,116	36

3.5. Monitoring and Evaluation

The weakest link in the implementation chain for SDG Target 3.d was the monitoring and evaluation framework. The audit said, "Target 3.d not being a priority in terms of SDG goal is in an almost neglected state." The SDG oversight mechanism, however, was robustly defined and included high-level committees led by the Prime Minister and the NPC Vice-Chair, as well as a dedicated parliamentary committee. Despite being comprehensive, this high-level oversight did not extend to the specific monitoring of IHR capacities.

The responsibility for monitoring this target was effectively devolved to the sole custodian, the National Focal Point (EDCD), who prepared and submitted the SPAR document single-handedly. There appeared to be no defined monitoring frameworks for Target 3.d at the provincial or local levels. The audit remarked, "even if some aspects of health are monitored at the provincial and local levels, they are not reported." This breached the vertical link in the M&E construct.

The absence of certain information was the primary reason for the monitoring failure. "Lack of data altogether or paucity of appropriately disaggregated relevant data or lack of up-to-date data impose limitations on SDGs tracking and monitoring." Not having a JEE was an important factor; however, it was exacerbated by a "mismatch of alignment in surveys conducted" by different agencies, which resulted in a lack of alignment and inconsistencies. The NPC had prepared M&E guidelines for provinces, and the Central Bureau of Statistics was aligning data with the SDGs; yet, these measures had not yet improved the condition for Target 3.d. The country was trying to measure its progress on a sophisticated target which did not have a verified baseline or time-series data, and no externally validated integrated multi-level reporting framework silos, which collapsed the unchanged monitoring and evaluation framework, against which the progress for this target had to be monitored.

4. Discussion

This performance audit has revealed an intricate and important analysis concerning performance in Nepal and the development of the public health system in line with SDG Target 3.d. The discussion chapters here bridge these insights and advance the argument that the nationalist and constitutional efforts in the country are now systematically being undermined by a trio of fundamental setbacks. These include an almost absolute neglect of health information systems and indicators, an utter inability to construct and operationalize health policies in a federal context, and a financial system that emphasizes post-event funding.

The widespread perception that the State Party Self-Assessment Annual Report (SPAR) serves as the sole measure of progress is the most inappropriate definition of oversight in the monitoring system (Linder et al., 2025). The gap since the last Joint External Evaluation (JEE) in 2015 has been a major primary source of data, for which the policymakers need an unbiased, third-party assessment of Nepal's International Health Regulations (IHR) capacities. The leap in the 2021 SPAR, which is frankly self-registered, raises a flag of caution, regardless of the cherry data. Stacked scores, along with the significant disparity between the existing line of movement and the National Planning Commission (NPC) roadmap, suggest that the national target expectations are grossly unrealistic. The country's current condition presents a worrying blind spot facing the intricate and demanding domain of public health preparedness, in desperate need of some form of constructive guidance (Mishra et al., 2025). Lying out an anchor and steering, no doubt, increases the chance of misplaced movement and rest. Such is the context of the Target 3.d data that, as a result of these setbacks, sits untouched in the entirety of the official advancement documents and in the most high-profile accountability frameworks (Board, 2019).

The second factor, a shift to a federal system, although a factor in the nation's democratic development, has also introduced very difficult problems in policy harmonization and institutional merger, which impact the health system's efficacy (Adil, 2023; Islam, 2025). The report reveals significant gaps between the constitutional division of powers and their actual implementation. The existence of strong federal policies, such as the National Health Policy, is questionable because these policies are not effectively translated to the provincial and community levels (Guglielmin et al., 2018). The fact that provincial SDG baseline reports omitted Target 3.d is a classic case of this vertical incoherence; this target is seen as a responsibility of the federal government, not the nation. There is also an example of horizontal incoherence, which is the unclear division of the functions of the MoH and the MOHA in public health emergency preparedness. The failure of the system to respond to the COVID-19 pandemic is an example of the actual operational failure described above in terms of incoherence (Bryce et al., 2022). The existence of temporary institutions, such as the COVID-19 Crisis Management Centre (CCMC), which operated alongside the disaster and health emergency laws, contributed to institutional noise, breakdown of command and control, and efforts duplication, which confused the system.

The translation of national public health emergency policies to sub-national levels in Nepal is failing due to a confluence of systemic barriers, rather than any single cause (Wasti et al., 2023). While unclear financial devolution forms a critical structural obstacle, evidenced by ambiguous conditional grants and the absence of earmarked funding for preparedness at provincial and local levels, this is compounded by a significant lack of administrative and technical capacity. However, underlying both these issues is a deeper lack of sustained political will and ownership at the sub-national tier. Without clear incentives, accountability mechanisms, or meaningful inclusion in policy formulation, provinces and municipalities remain passive recipients of top-down strategies rather than active partners in resilience-building. Thus, failure is tripartite: inadequate and unclear financing prevents action, insufficient capacity constrains execution, and absent political will negates the impetus for change.

This suggests that the system is not yet sophisticated enough to utilize its multi-tiered governance capability to develop a comprehensive, integrated strategy for responding to national-level crises. In the budgets, however, the disparity between the stated aims and the available funding is arguably the most significant structural malady. The sharply declining expenditure on the "Communicable, Infectious Disease, and Epidemic Control" Policy, and such repeated cuts at all levels of government, suggest that core public health functions are getting deprioritized (Bloom et al., 2022). This structural imbalance, also referred to as "underinvestment" or "disinvestment" in preparedness functions, such as health surveillance, labs, and response teams, results in a system that is weak and defenseless. Visible expenditure, especially that earmarked for and required to save the country, draws less attention than that spent on advanced preparation or known emergencies (Clarke et al., 2022). This vicious cycle obliterates the unattended preparedness functions, reinforcing the system and making it vulnerable to outbreaks that then command the famine emergency response funding. Such emergency response funding dominantly serves to deplete available, stable, and readily accessible reserves to enhance systemic capacity (Okyere et al., 2024). The underlying and dominant paradigm of such a financial system is, without a doubt, at odds with the proactive approach outlined in the IHR and SDG Target 3.d, specifically the pandemic preparedness and response paradigm.

The political economy of health financing favours visible "firefighting" over invisible preparedness due to divergent incentives and accountability timelines. Emergency response funding addresses immediate, high-visibility crises, generating tangible political returns through public recognition and media attention within short electoral cycles (Taheri Hosseinkhani, 2025). In contrast, investing in preparedness, strengthening surveillance and laboratory systems, or enhancing workforce training yields less visible, long-term benefits that are difficult to attribute to specific political actors. This creates a classic "preparedness paradox": when investments succeed, nothing happens, making them politically unrewarding; yet when emergencies occur, the lack of preparedness becomes tragically evident, often too late. Consequently, governments are incentivised to prioritise reactive, crisis-driven spending that addresses public pressure in the moment, while systematically underfunding preventive capacities whose value is only realised in the absence of catastrophe.

The principle of 'leave no one behind' (LNOB) is incorporated into the constitution but appears to be undermined by the fragmentation of the system strand (Madelene, 2020; Pant, 2021). Approaches such as the 'Reaching the Unreached' strategy were adopted as national-level policies without consideration of subnational units' governance frameworks, which are usually the first point of contact for the furthest communities. Equitable social strategies, without specific and actionable provisions assigned at the provincial and local levels, suggest inequitable social strategies at those levels (Wilson et al., 2018). These put forth policies are and will serve as lip service within the framework of operational social policies.

5. Conclusion

The special audit indicates that Nepal's public health system, under SDG Target 3.d, has made insufficient progress due to systemic issues that are expected to hinder the achievement of the 2030 target. Stagnation in progress, attributable to the absence of an Evaluation Externally Joint, is recognized as a primordial systematic deficiency, dating back to 2015, and relying on self-collected information, suggests that the country's paramount aim is overstated. There is a constitutional and policy framing on health; however, the adoption is compromised on the basis of a differential balance of internal and international vertical and horizontal relationships, to the principles of federalism, which results in a loss of precise

delineation of constitutional guarantees, diversity, and collaboration as demonstrated through the centrally coordinated health stratified coping mechanisms to the pandemic of COVID-19.

In addition, the government's financial approach was still out of synchronization with the tenets of preparedness. The persistent pattern of underinvestment in core capacities for epidemic control and laboratory services, alongside reckless outlays and a reactive "emergencies of the 'Firefighting' approach Costly Over Investment" response, indicates misplaced investment priorities. The "firefighting" investment approach, in the absence of strong vehicles for monitoring and evaluation, is incapable of gauging progress in the sub-national "below" set of health systems, creating a health system that is vulnerable to shocks, and shocks to health are created.

Strategic reactivity, in the form of enclave politics, the achingly slow institutional building, and the lingering effects of the pandemic to this day, layers complaints onto the country's political epidemiology. This is highly indicative of the range of conditions that precipitate a paradigm collapse. More specifically, the need is to shift the Center for Integration of Health and Wellness Systems to provide the strongest basic health services to organizations for health system contracting, with clear delegation of authority and accountability for core IHR capacities. The fundamental constituency within a public policy system remains unresponsive to the rest of the system, rendering the system unworkable or unhealthy as a whole.

Acknowledgements

I would like to extend my heartfelt gratitude to the Office of the Auditor General, Nepal for providing the opportunity to conduct research in this topic. I am indebted to the supervisor Mr. Shreekumar Rai and the team leader Mr. Rajendra Raj Ojha and the other team members of the audit team, Mr. Yagya Prasad Wasti who contributed to the successful completion of this study. Their dedication, expertise, and commitment were instrumental in the realization of our research objectives.

References

Adil, M. B. (2023). Critical analysis of the role of institutional mechanism in strengthening federal-provincial harmony–Way forward. *KJPP,* 2(2), 1.

Bloom, D. E., Kuhn, M., & Prettner, K. (2022). Modern infectious diseases: macroeconomic impacts and policy responses. *Journal of Economic Literature, 60*(1), 85-131.

Board, G. P. M. (2019). *A world at risk.* World Health Organization.

Bryce, C., Ring, P., Ashby, S., & Wardman, J. K. (2022). *Resilience in the face of uncertainty: early lessons from the COVID-19 pandemic*. In COVID-19 (pp. 48-55). Routledge.

Clarke, L., Patouillard, E., Mirelman, A. J., Ho, Z. J. M., Edejer, T. T. T., & Kandel, N. (2022). The costs of improving health emergency preparedness: A systematic review and analysis of multi-country studies. *Eclinical Medicine*, 44.

GoN (2017). *National Policy Strategic Plan: Disaster Management*. https://files.acquia.undp.org/public/migration/np/National_policy_strategic_Plan_Disaster_Managment_2018-2030.pdf

Guglielmin, M., Muntaner, C., O'Campo, P., & Shankardass, K. (2018). A scoping review of the implementation of health in all policies at the local level. *Health policy, 122*(3), 284-292.

Islam, S. (2025). Public Finance and Policy Effectiveness A Review Of Participatory Budgeting In Local Governance Systems. Available at SSRN 5287147.

Linder, A. G., Zhao, C., Samuelson, B. K., Standley, C. J., & Sorrell, E. M. (2025). Assessing the Revision of the States Parties Self-Assessment Annual Reporting Tool: Developing a Solution for an Historical Analysis of Compliance. *Health security, 23*(3), 177-185.

Madelene, H. (2020). Leave No One Behind in Education: Advocating for disability rights in Nepal.

Mishra, S. R., Ghimire, K., Khanal, V., Aryal, D., Shrestha, B., Khanal, P., ... & Adhikari, B. (2025). Transforming health in Nepal: a historical and contemporary review on disease burden, health system challenges, and innovations. *Health Research Policy and Systems, 23*(1), 61.

Nepal, P., Khanal, N. R., & Pangali Sharma, B. P. (2018). Policies and Institutions for Disaster Risk Management in Nepal: A Review. *Geographical Journal of Nepal, 11*, 1–24. https://doi.org/10.3126/gjn.v11i0.19546

NHSSP (2022). Health Sector Budget Analysis: First Five Years of Federalism. https://www.nhssp.org.np/Resources/HPP/Final%20Budget%20Analysis%20of%20Health%20Sector-Five%20Years%20of%20Federalism.pdf

NPC (2017). Sustainable Development Goals: Status and Roadmap (2016-2030). https://www.npc.gov.np/content/4934/4934-sustainable-development-goals/

NPC (2024). The Fifteenth Plan (Fiscal Year 2019/20 - 2023/24). https://www.npc.gov.np/content/4551/4551-the-fifteenth-plan-fiscal-yea/

OAGN (2023). *Report on audit of strong and resilient national public health system (related to SDG target 2 d)*.

Okyere, D. O., Lomazzi, M., Peri, K., & Moore, M. (2024). Investing in health system resilience: A scoping review to identify strategies for enhancing preparedness and response capacity. *Population Medicine*, 6(2), 1-21.

Pant, J.R. (2021). Analysis of education policies in Nepal from the lens of leave no one behind principle. *A Nepalese Journal of Participatory Development,* 50.

Raszkowski, A., & Bartniczak, B. (2019). On the road to sustainability: Implementation of the 2030 Agenda sustainable development goals (SDG) in Poland. *Sustainability*, 11(2), 366.

Rayamajhee, B., Pokhrel, A., Syangtan, G., Khadka, S., Lama, B., Rawal, L. B., ... & Yadav, U. N. (2021). How well the government of Nepal is responding to COVID-19? An experience from a resource-limited country to confront unprecedented pandemic. *Frontiers in public health*, 9, 597808.

Srivastava, P., & Khan, A. S. (2024). Integrating Sustainable Development Goals with the Management of Natural and Technological Hazards and Disaster Risk Reduction. *Geospatial Technology for Natural Resource Management*, 83-131.

Taheri Hosseinkhani, N. (2025). *The Electoral Consequences of Natural Disasters: A Dynamic Fixed-Effects Analysis*. Available at SSRN 5354804.

Wasti, S. P., Van Teijlingen, E., Rushton, S., Subedi, M., Simkhada, P., & Balen, J. (2023). Overcoming the challenges facing Nepal's health system during federalisation: an analysis of health system building blocks. *Health Research Policy and Systems, 21(*1), 117.

Wilson, C. E., Morrison, T. H., & Everingham, J. A. (2018). Multi-scale meta-governance strategies for addressing social inequality in resource dependent regions. *Sociologia Ruralis, 58*(3), 500-521.

World Health Organization. (2023). *Joint external evaluation of IHR core capacities of the Federal Democratic Republic of Nepal: mission report*, 28 November-2 December 2022. World Health Organization.