

National Guidelines for Disability Inclusive Health Services, 2019



Government of Nepal

Ministry of Health and Population

Department of Health Services

Epidemiology and Disease Control Division

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ACRONYMS

AWPB	Annual Workplan and Budget
CRPD	Convention on the Rights of Persons with Disabilities
DoHS	Department of Health Services
DPO	Disabled People’s Organisation
EDCD	Epidemiology and Disease Control Division, Department of Health Services
ENT	Ear, Nose and Throat Specialist
FCHV	Female Community Health Volunteer
GESI	Gender Equality and Social Inclusion
GoN	Government of Nepal
HMIS	Health Management Information System
INGO	International Non-Governmental Organisation
LCDMS	Leprosy Control and Disability Management Section
MoHP	Ministry of Health and Population
MoSD	Ministry of Social Development
MoWCSC	Ministry of Women, Children and Senior Citizens
NFDN	National Federation of Disability, Nepal
NGO	Non-Governmental Organisation
NHEICC	National Health Education Information and Communication Centre
NHTC	National Health Training Centre
PHCC	Primary Health Care Centre
PHTC	Provincial Health Training Centre
SDG	Sustainable Development Goals
SSU	Social Service Unit
TWG	Technical Working Group

Chapter 1 Introduction

1.1 Background

Across the country, people with disabilities have poorer health outcomes, lower education achievements, less economic participation and higher rates of poverty than people without disabilities. This is partly because people with disabilities experience barriers in access to quality basic health services even though they have a greater need to access health services. As a result, people with disabilities experience higher levels of unmet health needs than people without a disability.

Nepal ratified the Convention on the Rights of Persons with Disabilities (CRPD) and the Optional Protocol to the Convention on the Rights of Persons with Disabilities in 2009. Article 25 of the Convention affirms that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination and that parties to the convention shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. Progress in building the evidence base, political commitment to implementing the CRPD, institutionalizing the rights of persons with disabilities, and providing equal access to health services and changing discriminatory attitudes and social norms has been slow.

The Constitution of Nepal provides significant advancement for the rights of persons with disabilities. The Constitution guarantees human rights and fundamental freedom to all its citizens and includes provision to improve the life of persons with disabilities. The Constitution provides people with physical or intellectual disability the right to participate in the structure of the State and inclusion in the benefits of public services. In 2017, the Government enacted the Rights of Persons with Disabilities Act in line with the CRPD. The Act embraces a human rights perspective and ensures equal access to education, health, employment, public physical infrastructure, transportation and information and communication services. It prohibits all kinds of discrimination on the basis of disability. The Disability Management (Prevention, Treatment and Rehabilitation) Policy, Strategy and Ten-Year Plan (2017-2026) provides persons with disability equal access to basic health services as other citizens and need-based specialised health services and rehabilitation.

1.2 Purpose and rationale of the guidelines

Targeted to health service providers at primary, secondary and tertiary level, this guideline aims to:

- Enable health service providers to meet their statutory responsibilities related to the health rights of persons with disabilities.
- Provide practical information to health service providers on the delivery of respectful and dignified health care, and how they can reduce the attitudinal, communication and structural barriers that persons with disabilities face in accessing quality health services.
- Provide guidance to primary health care staff on their responsibility to integrate disability inclusion into the delivery of primary health care services and how.
- Provide guidance to secondary and tertiary hospitals on their responsibility to integrate disability inclusion into the delivery of hospital care and how to progressively realise disability inclusive medical services, disability-specific specialist services and health-related rehabilitation.

- Support education and training on disability inclusive health services, accessibility and client-oriented health care.
- Assist health management to organise and manage disability inclusive health services and leverage resources and partnerships to help meet the health needs of persons with disabilities.

This guideline seeks to create coherent health sector understanding of disability inclusion principles and health practices. It provides guidance on how to mainstream disability inclusion in health service delivery, and how health providers can operationalise their responsibilities under disability related laws and policies.

1.3 Methodology for developing the guidelines

The Ministry of Health and Population (MoHP), Department of Health Services (DoHS), Leprosy Control and Disability Management Section (LCDMS) of the Epidemiology and Disease Control Division (EDCD) led the development of the guidelines through leadership of a Technical Working Group (TWG). The TWG included experts drawn from within the MoHP, Department of Health Services (DoHS) and disabled people's organisations (DPOs) representing persons with different types of disabilities. The TWG approved the plan for preparing the guidelines, the scope and contents of the guidelines and the processes of review, consultation and information generation. The TWG undertook a review of the international and national literature on how to improve accessibility to health services for persons with disabilities, analysis of the CRPD and Nepal's legal framework for persons with disabilities. The TWG developed the scope, components and provisions of the guidelines.

Consultations and focused discussions at the federal, provincial and local levels were undertaken to collect experiences and reflections on the current status of health service delivery to persons with disabilities, including health needs and barriers to access, and to identify measures required to meet the needs and rights of persons with disabilities.

At the federal level, consultations were held with the Ministry of Women, Children and Senior Citizens (MoWCSC), MoHP, DoHS, National Federation of Disability Nepal which is a disabled people's organisation, disability-specific federations and associations, non-government organisations (NGOs), persons with disabilities, medical experts and social activists.

At provincial and local levels, consultations with the Ministry of Social Development, Health Directorate officials, provincial hospitals and health facility staff explored the appropriateness, adequacy and applicability of the guidelines. At the local level, Social Development Division, health units and health facility staff were consulted on how to improve disability inclusive health services. At provincial and local levels, local representatives, government staff and members of DPOs were consulted on how to institutionalise the guidelines into the provincial and local level health service delivery system.

A second stage of consultations took place once the draft guidelines had been drawn up. The draft guidelines were circulated to stakeholders involved in the initial consultations. Feedback was collated and revisions made. The guidelines were reviewed and finalised at a national workshop.

1.4 Users of this guidelines

The primary intended users of this guidelines are:

- a. All health staff: To gain a better understanding of disability and have clarity on disability inclusion principles and good practices in the delivery of health services.
- b. Front-line health staff: To understand how to respectfully interact with and assist persons with disabilities.
- c. Staff involved in project planning, implementation, monitoring and evaluation: To identify entry points for disability mainstreaming and effective delivery of disability inclusive health services at the federal, provincial and local levels.

Other stakeholders that may find this guideline informative are:

- d. External development partners, national and international non-governmental organisations.
- e. Organisations represented in, and individuals participating in the management committees of hospitals and health facilities.
- f. Civil society organisations including disabled people’s organisations, community organisations and interest groups.
- g. Research organisations, experts and professionals in relevant fields.

1.5 Definition of key terms

Unless the subject or the context otherwise requires, the key terms in the guidelines are defined as per the following:

- a. **Disability** is the result of the interaction between persons with impairments and attitudinal and environmental barriers. Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which, when in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others.
- b. **Persons with disabilities** include those who have long-term physical, mental, intellectual or sensory impairments, which in interaction with various barriers hinder their full participation in society on an equal basis with others.
- c. **Access, accessibility and accessible** refers to ensuring persons with disabilities can access health services and facilities on an on an equal basis with others in a way that promotes their dignity and independence. This requires removing the physical, communication, attitudinal, financial and institutional barriers that persons with disabilities face in accessing health services.
 - i. Physical access refers to the four steps:
 - A. Reach – being able to move around the community and physically reach a health service or facility. This includes making transport accessible to people with disabilities so they can make the journey to a health facility.
 - B. Enter – being able to enter inside a health facility. This may require adaptation to the health facility such as the provision of ramps, building signage in easy to read lettering or Braille or other physical structures to enable people with disabilities to locate and enter into a health facility.
 - C. Circulate – being able to move about safely inside the entire health facility including from one building to another or one floor to another. This may

require structural changes to the building so that people with physical disability can move safely, and/or additional signage so that people with vision or cognitive impairment can identify where to go.

- D. Use – being able to use all services and facilities within the building. This includes for example the provision of furniture and equipment adapted to the needs of people with disability including beds that can be lowered so people can mount them, the provision of accessible toilet facilities and the use of alarms and signals for people who are deaf or hard of hearing.
 - ii. Communication access refers to ensuring interpersonal communication and the provision of information is accessible to persons with disabilities so they do not miss out on information. This includes adapting the use of language and provision of accessible information materials. Disability access symbols signpost services that are accessible to persons with disability including for example in building signage, floor plans and health facility maps. See the definition of communication below for practical examples of accessible communication medium and products.
 - iii. Attitudes that promote the dignity, rights and respect of persons with disabilities are an important contributing factor to access health services. This includes eliminating negative attitudes that result in stigmatizing, patronising and discriminating against persons with disabilities which can lead to their exclusion from health services. For example, health worker attitudes that persons with disabilities should not be sexually active denies them access to sexual rights and services.
 - iv. Financial access removes the financial barriers that persons with disabilities face in accessing health services. This is particularly important because persons with disabilities in Nepal are more likely to be poor than others due to the additional barriers they face in participating in the economy.
 - v. Institutional barriers faced by persons with disabilities include the weak implementation of laws and policies that uphold the rights of persons with disabilities and gaps in the health system and health service that leave persons with disabilities invisible and fail to respond to their health needs on an equal basis with others. For example, the lack of evidence on the use of health services by people with disabilities and the lack of opportunity for persons with disabilities to participate in decision making bodies that oversee the health system are institutional barriers to realising the rights of persons with disabilities.
- d. **Barriers** are obstacles that hinder or prevent persons with disabilities from participation or living independently, working, travelling and/or having access to buildings, services, forms and information on an equal basis with others. Barriers can be attitudinal, physical, environmental, financial, communication and institutional. For example, environmental barriers may prevent a person with a disability from travelling and/or having access to buildings. An example is a building with steps as the sole means of entry, which would prevent people in wheelchairs from visiting that building.
- e. **Accountability** refers to the obligation of the health service provider and its staff members to be responsible and answerable for delivering health services with quality of care and satisfaction of the person with disability in an equitable, transparent and responsive way. It

includes achieving objectives and results in response to mandates, fair and accurate reporting on performance results, objective use of resources, and all aspects of performance in accordance with regulations, rules and standards.

- f. **Assistive technology** refers to an umbrella term that includes assistive, adaptive and rehabilitative devices for people with disabilities. Assistive technology promotes greater independence by enabling people to perform tasks that they were formerly unable to accomplish, or had great difficulty accomplishing, by providing enhancements to, or changing methods of interacting with, the technology needed to accomplish such tasks. See Annex 1 for the Government's priority list of assistive devices¹.
- g. **Basic health care service package** is a comprehensive set of preventive, promotive, curative, rehabilitative and allied health services provided within the boundary of available resources to satisfy the basic healthcare needs of the population. The Public Health Act 2017, provides the following services free of cost to citizens: immunisation, integrated maternal, newborn and child health and nutrition, family planning, abortion, prevention and treatment of communicable disease and non-communicable disease, physical disability, mental health, geriatric, general emergency, health promotion, Ayurveda and other government recognised alternative health services. Government of Nepal and subnational governments have the authority to add to this list.
- h. **Communication** that is accessible and disability inclusive refers to sign languages (*sanketik bhasha*), display of text, Braille, tactile communication, large print, accessible multimedia as well as written, audio, plain-language, human-reader and augmentative and alternative modes, means and formats of communication, including accessible information and communication technology.
- i. **Continuous improvement** describes the ongoing effort of an organisation to improve services, systems, processes or products to maximise benefits for its clients. The process of continuous improvement of health services relies on evidence-based information to support the Government's efforts in achieving health sector goals and outcomes. This also means adapting to the changing needs of the community or people using services and ties in with the CRPD's concept of progressive implementation.
- j. **Discrimination** on the grounds of disability refers to all acts of denial, creating a barrier, exclusion or disrespectful behaviour towards persons with disabilities in exercising their right to basic health or essential health services equal to others. Discrimination also includes denial of reasonable accommodation in the provision of health services necessary for ensuring quality of life.
- k. **Early detection** is the discovery or diagnosis of an impairment in-utero, shortly after birth or through screening in school.

¹ Ministry of Health and Population. 2018. Priority Assistive Product List of Nepal.

- l. **Health** refers to a state of physical, mental and social well-being and not merely the absence of disease or infirmity.
- m. **Health service provider** refers to an organisation (government, non-government, private for profit or community-based), established and operating under the law to provide preventive, curative, promotional and/or rehabilitative health care services.
- n. **Impairment** is a limitation in body function or body structure due to disease, illness, injury or genetic factors.
- o. **People-first language** aims to avoid perceived and subconscious discrimination when talking with or about people with disabilities. The basic idea is to impose a sentence structure that names the person first and the condition second, for example "people with disabilities" rather than "disabled people" thus the language should focus on acknowledging the person before the disability and shifting the focus away from the condition of impairment.
- p. **Rehabilitation** refers to regaining skills, abilities or knowledge that may have been lost or compromised as a result of acquiring a disability. It is a planned process with defined goals, timeframes and means in which professions and/or services assist a person to achieve best possible functioning and coping capabilities, thereby promoting independence and participation in society. In contrast, habilitation refers to the process of assisting persons with disabilities to attain, keep or improve skills or functioning. In the case of habilitation, the person may not have had the skills in the first place to regain.
- q. **Social Service Units (SSU)** are the institutional mechanism established at different levels of hospitals to facilitate free and partially free health service delivery to patients from targeted population groups. The targeted groups of SSU are the poor, destitute, persons with disabilities, senior citizens, survivors of gender-based violence, natural disaster survivors, Female Community Health Volunteers (FCHV), persons with intellectual disabilities, life-saving care, people in police custody, family members of national martyrs, endangered groups and other marginal and vulnerable groups as decided by the hospital.
- r. **Wellness** refers to the multidimensional, positive health possessed by persons with disabilities. It is an active process of becoming aware and making choices toward a healthy and fulfilling life. It is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.

Chapter 2 Review of Disability and Health Care in Nepal

2.1 Understanding disability

The Convention on the Rights of Persons with Disabilities² recognises that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others. It defines disability as:

“Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments, which in interaction with various barriers hinder their full participation in society on an equal basis with others.”

Disability refers to difficulties encountered in any or all three areas of functioning:

- **Impairment** is a limitation in body function or body structure due to disease, illness, injury or genetic factors
- **Activity limitations** are difficulties in executing activities – for example, walking
- **Participation restrictions** are problems with involvement in any area of life – for example, facing discrimination in health service use or employment or mobility.

2.1.1 Different models of disability

There are four main models of disability: the charity model, the medical model, the social model and the human rights model. The first three focus on the source of the problem, whilst the last focuses on finding solutions and creating an enabling environment for all.

The charity model focuses on the individual and tends to view people with disabilities as victims or objects of pity, their impairment being their main identifier. They are seen as recipients and beneficiaries of services. This approach sees people with disabilities as passive, tragic or suffering and requiring care. It assumes that it is the community and society’s responsibility to arrange all services for these vulnerable people.

The medical model also focuses on the individual and sees disability as a health condition, an impairment located in the individual. It assumes that by addressing the medical ailment this will resolve the problem. In this approach a person with disabilities is primarily defined as a patient, in terms of their diagnosis requiring medical intervention. Disability is seen as a disease or defect that is at odds with the norm and that needs to be fixed or cured.

The social model developed as a reaction against the individualistic approaches of the charitable and medical models. It focuses on society and considers that the problem lies with society, that due to barriers be they social, institutional, economic or political, people with disabilities are excluded. This approach focuses on reforming society, removing barriers to participation, raising awareness and changing attitudes, practice and policies.

The bio-psychosocial or rights-based model is based on the social model and shares the same premise that it is society that needs to change. This approach focuses on equity and rights and looks to include all people equally within society: women and men, girls and boys regardless of background or any type

² Article 1 of the Convention.

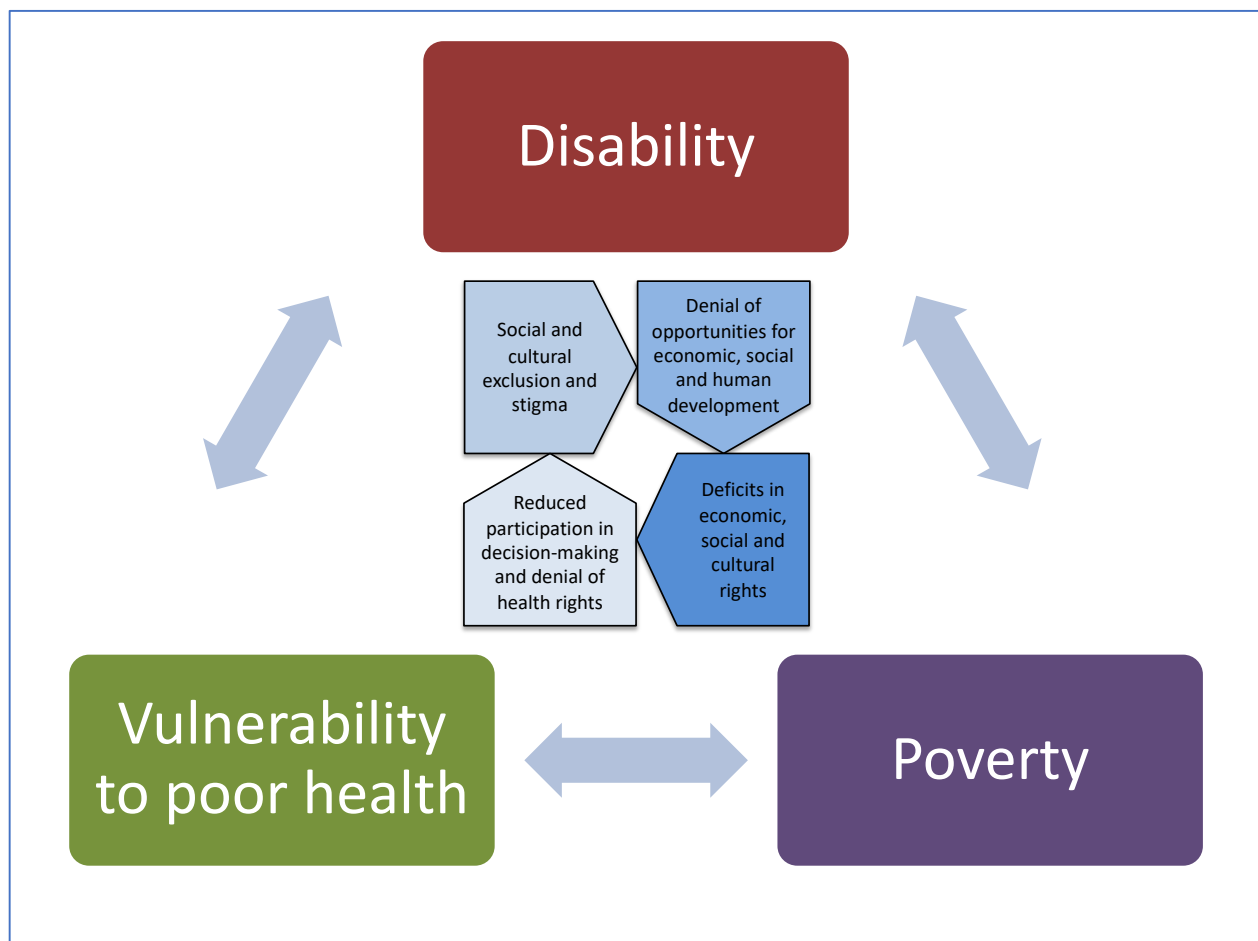
of characteristic. It is founded on the principle that human rights for all human beings is an inalienable right and that all rights are applicable and indivisible. It takes the CRPD as its main reference point and prioritises ensuring that duty bearers at all levels meet their responsibilities. This approach sees people with disabilities as the central agent in their own lives as decision makers, citizens and rights holders. As with the social model, it seeks to transform unjust systems and practices.

2.2 Inclusive health services for people with disabilities

Social inclusion is a process that ensures that those at risk of poverty and social exclusion gain the opportunities and resources they need to participate fully in economic, social and cultural life and to enjoy a standard of living and well-being that is considered normal in the society in which they live. It ensures that such populations participate in decision making on matters that affect them and achieve access to resources, opportunities and services to enjoy their fundamental rights.

Persons with disabilities are often excluded (either directly or indirectly) from development processes and health services because of physical, attitudinal and institutional barriers. The effects of this exclusion are increased inequality, discrimination and marginalization in their health. To change this, a disability inclusive approach must be implemented in the health service.

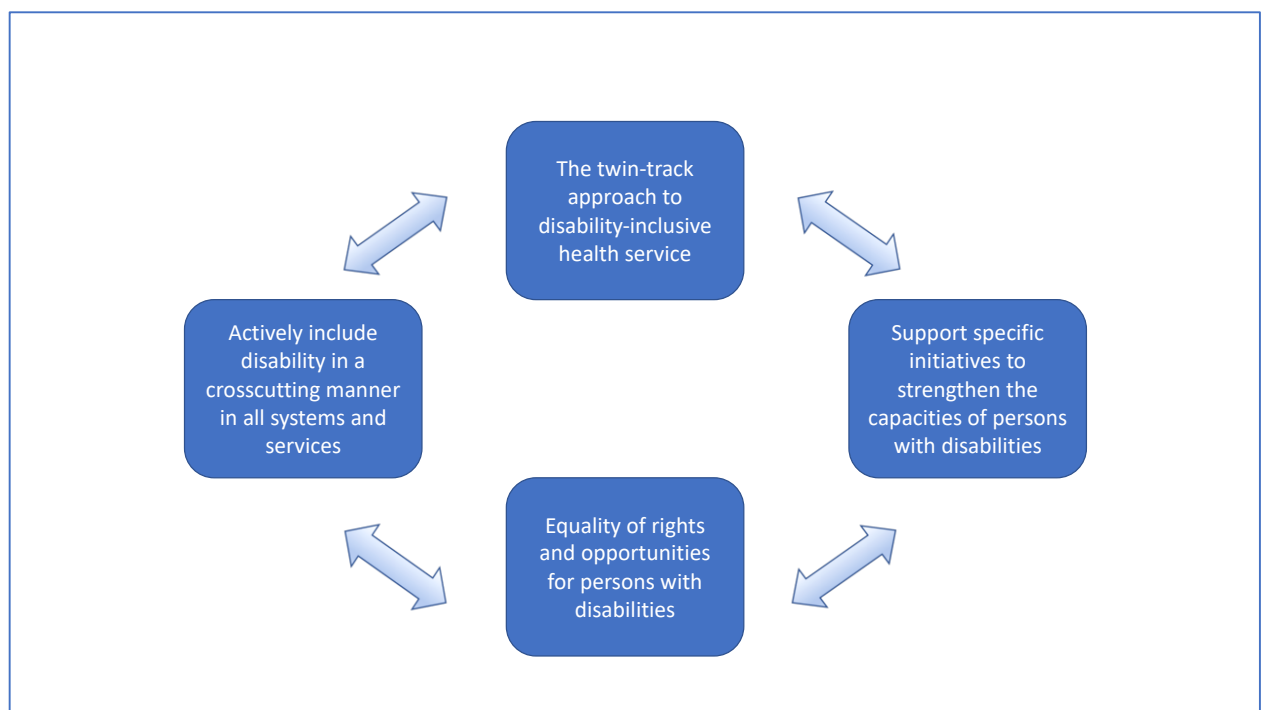
Figure 1: The interconnection between disability, poverty, health vulnerability and human rights



Disability inclusive health services means ensuring people with disabilities have the same rights, participation and inclusion in health services as the general population. This may require changes to the health system such as reasonable accommodations and the education of health workers to change negative attitudes and behaviours. Disability inclusive health services also recognise and respond to the needs of health staff that have disabilities to enable them to participate and be effective in an equal manner to non-disabled health staff.

A twin-track approach is being taken in Nepal to achieve disability inclusion in the health sector. This involves (1) ensuring all mainstream programmes and services are inclusive and accessible to persons with disabilities, while at the same time (2) providing targeted disability-specific healthcare support to persons with disabilities.

Figure 2: The twin track approach to disability inclusion



The principles underlying the twin-track approach are:

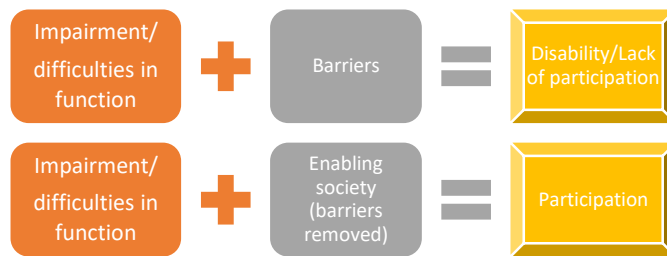
- **Non-discrimination** to ensure that all persons with disabilities have equal opportunities to access and benefit from health services and programmes and that no action by the health system contributes to creating or reinforcing barriers.
- **Awareness** of disability and its implications – a key to inclusive health service.
- **Participation** and active involvement of people with disabilities.
- **Comprehensive accessibility** by addressing the barriers that people with disabilities face in accessing health services especially attitudinal, structural, communication and institutional barriers.
- **Empowerment** of persons with disabilities to enable them to control their lives through informed decisions.
- **Gender equality** in health services.

2.2.1 Barriers to accessing health services by persons with disabilities

Barriers that hinder participation of persons with disabilities are described in four categories – attitudinal, structural, communication and institutional. Health service providers need to understand these barriers to help reduce or remove them and help facilitate the inclusion of persons with disabilities in health services.

1. **Attitudinal barriers:** One of the most significant barriers to effective participation and inclusion of persons with disabilities are negative attitudes and stereotypes. Nepalese society often sees persons with disabilities as incapable, dependent or weak. This perpetuates their segregation and exclusion from society. For example: a health-care worker who thinks that women with disabilities are not or should not be sexually active and thus does not provide them with family planning services creates a barrier for women with disabilities to access health care.
2. **Structural barriers** are obstacles in natural or man-made environments that prevent access or hinder persons with disabilities from moving around independently. For example: a health clinic with steps at the entrance, pathways without tactile guide markers, narrow doorways and squat-style toilets creates barriers for persons with physical impairment and persons with vision impairment. Health facility premises without accessibility considerations for health staff members with disabilities create barriers for them to effectively undertake their work.
3. **Communication barriers** may be experienced by persons with difficulties in seeing, hearing, speaking, reading, writing and understanding. These persons often communicate in different ways to persons without disabilities, and if adaptations are not made, they may be unable to understand or convey information. Examples of communication barriers include:
 - i. A health facility with signage in small, unclear font, without pictures or diagrams and without raised lettering or Braille creates a barrier for persons with vision impairment.
 - ii. A workshop using spoken communications without providing for sign language interpretation creates a barrier for persons with hearing impairments and sign-language users.
 - iii. A health clinic with high service counters and patient information desks creates a barrier for persons with physical impairment who use wheelchairs.
4. **Institutional barriers:** In Nepal the legal and policy framework for disability inclusion is now strong but the risk of weak enforcement persists and this is an institutional barrier. Institutional barriers are difficult to identify because they are often entrenched within social and cultural norms and impacted by budget constraints.

The interaction between impairment and barriers for a person with disability is disabling and results in a lack of participation. It is therefore society that creates a disabling situation for persons with disabilities. When barriers are removed, persons with disabilities are able to participate on an equal basis with others. This means that people with the same type of impairment may have completely different lives depending on the barriers they face, where they live, what access they have to services, and how their communities perceive and accommodate them.



In Nepal, persons with disabilities, disabled people’s organisations (DPOs) and organisations working for persons with disability report multiple barriers to persons with disabilities accessing health care. Barriers which are particularly severe for those residing in rural and unreachable areas are:

- Physically inaccessible health service facility
- Lack of appropriate transport to enable them to seek medical care or rehabilitation services
- Lack of communications and accommodation in health care settings
- Lack of wellness support, recognition of dignity and respect
- Lack of financial support and provision of caregiver
- Untrained health personnel and inadequate staffing at health facilities
- Negative attitudes of health care providers
- Harmful practices, particularly in relation to persons with psychosocial disabilities
- Denial of treatment on grounds of disability

2.2.2 Participation and empowerment of people with disability

Participation by persons with disabilities is essential to ensure health services are relevant and effective and meet the needs of all people with disabilities. Persons with disabilities are the ones who best understand the barriers they face and the possible solutions. “Nothing about us without us” has been the slogan of persons with disabilities and their representative organisations, known as ‘Disabled People’s Organisations’, and should also be a guiding principle for the health service provider, in accordance with the CRPD as well as the legal and operational frameworks on disability inclusive health services in Nepal. The National Federation of Disability, Nepal is one such DPO and has over 100 chapters in the country. Participation can also empower and build the confidence of persons with disabilities and raise broader community awareness of the abilities and contributions persons with disabilities can make.

2.3 Prevalence and different types of disability in Nepal

Estimates of disability prevalence in Nepal are underreported, especially among older people, girls and women, because of cultural and social norms and stigma that discourage recognition of disability and lack of data collection in government reporting systems. The 2011 Census estimated the disability prevalence rate at 1.94% but this is widely considered as an underestimate and is significantly less than the estimate that 15% of the global population are living with disability. Early identification of disability in Nepal is inadequate and current disability assessments follow an outdated, narrow medical approach. The result is a substantial number of persons with disabilities live without the necessary services and protection they are entitled to.

Table 1: Prevalence and types of disability in Nepal, Census 2011

		2011 Census
Total population		26,494,504
Total persons with disability		513,301
Disability prevalence rate		1.94
Types of disability (in percentage)		
1	Physical disability	36.33
2	Vision impairment	18.46
3	Hearing	15.45
4	Vision and hearing	1.84
5	Speech related	11.47
6	Mental health impairment	6.03
7	Intellectual disability	2.90
8	Multiple disability	7.52
	Total	100

Table 2: Prevalence of disability by sex and urban-rural location, Census 2011

	Urban	Rural	Nepal
Female	1.12	1.82	1.71
Male	1.30	2.37	2.18
Total	1.21	2.09	1.94

2.4 Types of health conditions and health needs of people with disability

2.4.1 Health conditions of people with disability

The health conditions of persons with disability can be explained in terms of primary health condition, secondary health conditions and co-morbid health conditions.

The **primary health condition** is the possible starting point for impairment, an activity limitation or participation restriction. Examples of primary health conditions include depression, arthritis, chronic obstructive pulmonary disease, ischaemic heart disease, cerebral palsy, bipolar disorder, glaucoma, cerebrovascular disease, and Down syndrome. A primary health condition can lead to a wide range of disabilities, including mobility, sensory, mental and communication.

A **secondary health condition** is additional to and resulting from the primary condition. Examples include pressure ulcers, urinary tract infections, and depression. Secondary conditions can reduce functioning, lower the quality of life, increase health care costs, and lead to premature mortality. Many such conditions are preventable and can be anticipated from primary health conditions.

A **'co-morbid condition'** is an additional condition independent of and unrelated to the primary condition. The detection and treatment of co-morbid conditions are often not well managed for people with disabilities and can later have an adverse effect on their health. For example, people with intellectual impairments and mental health illness commonly experience "diagnostic overshadowing". This is when a health professional wrongly presumes that the physical symptoms their patient is presenting is a consequence of their mental illness and the result is that the patient with mental illness receives inadequate diagnosis or treatment. Examples of co-morbid conditions include cancer or hypertension for a person with an intellectual impairment.

2.4.2 Health needs of people with disability

The health needs of people with disability can be described in terms of general health care needs and specialist health care needs within the framework of universal health coverage.

People with disabilities require health services for **general health care needs** like the rest of the population. General health needs include health promotion, preventive care (immunization, general health screening), treatment of acute and chronic illness, and appropriate referral for more specialized needs where required. These needs should all be met through primary health care in addition to secondary and tertiary as relevant. Access to primary health care is particularly important for those people who experience a thinner margin of health to achieve their highest attainable standard of health and functioning.

Some people with disabilities may have a greater need for **specialist health care** than the general population. Specialist health care needs may be associated with primary, secondary, and co-morbid health conditions. Some people with disabilities may have multiple health conditions, and some health conditions may involve multiple body functions and structures. Assessment and treatment in these instances can be quite complex and necessitate the knowledge and skills of specialists.

2.5 Health rights of people with disability and obligations of the State

The Constitution of Nepal has made provision for the health rights of persons with disabilities in line with the Convention on the Rights of Persons with Disabilities (CRPD).

After ratifying the CRPD, Nepal has the obligation to:

- Adopt legislation and other appropriate administrative measures where needed
- Modify or repeal laws, customs or practices that discriminate directly or indirectly
- Include disability in all relevant policies and programmes
- Refrain from any act or practice inconsistent with the CRPD
- Take all appropriate measures to eliminate discrimination against persons with disabilities by any person, organisation, or private enterprise.

Nepal seeks to fulfil its obligations through constitutional, policy, legal and operational mechanisms as presented below.

2.5.1 The Constitution of Nepal

The Constitution of Nepal has provided the ground for special provisions by law for the protection, empowerment or development of citizens including persons with disabilities. It has provided that³:

1. Every citizen shall have the right to free basic health services from the State, and no one shall be deprived of emergency health services.
2. Every person shall have the right to information about his or her medical treatment.
3. Every citizen shall have equal access to health services.
4. Every woman shall have the right to safe motherhood and reproductive health.
5. Women shall have the right to obtain special opportunity in health and social security, on the basis of positive discrimination.
6. Children with disabilities, shall have the right to special protection and facilities from the State.
7. Special provision shall be made by law in order to provide health and social security to the *Dalit* community.
8. Under the right to social security, citizens with disabilities shall have the right to social security, in accordance with law.

2.5.2 United Nations Convention on the Rights of Persons with Disability

The Convention is the guiding instrument to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity. The Convention states that every person with disabilities has the right to respect for his or her physical and mental integrity on an equal basis with others. The Convention recognizes people with disabilities as active subjects, capable of claiming their rights and making decisions about their lives based on their free and informed consent.

There are eight guiding principles that underlie the Convention on the Rights of Persons with Disabilities:

1. Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons
2. Non-discrimination
3. Full and effective participation and inclusion in society
4. Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity
5. Equality of opportunity
6. Accessibility
7. Equality between men and women
8. Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities

It recognizes that persons with disabilities have the right to the highest attainable standard of health and that the State must recognize that right without discrimination on the basis of disability. The right to health includes access to basic health services as well as specialized rehabilitation services, including residential care, community-based care and support services. Services should be provided on an individual or "person-centred" basis with due regard to the range of support services required (e.g., supportive devices, nursing, personal assistance, respite, rehabilitation, day activities and caring assistance).

³ Article 35, 39, 40, 43 of the Constitution of Nepal.

2.5.3 Public Health Act, 2018

The Public Health Act, 2018 includes provision for creation of an emergency health care fund for target populations including persons with disabilities⁴.

2.5.4 National Health Policy, 2014

The National Health Policy 2014 embraces a human rights-based approach and provides a strong foundation for gender equality and social inclusion. The goal is to ensure health for all citizens as a fundamental human right by increasing access to quality health services through provision of a just and accountable health system. One of the guiding principles of the policy is to ensure health services provisioned by the state are accessible to poor, marginalized, and vulnerable communities based on equality and social justice. The policy aspires to universal health coverage and provision of basic health services free of cost to the client.

2.5.5 The Fourteenth Plan

The Fourteenth Plan (2015/16 – 2018/19) includes the goal of improving the quality of life of people with disabilities by increasing their access to health services. To achieve this goal, the Plan aims to ensure public services have disability-friendly and accessible physical infrastructure, promote collaboration and partnerships with non-governmental and private sector organisations in the establishment and expansion of disability-related rehabilitation centres for persons with intellectual disability, autism, complete and severe disabilities. The Plan also includes strategies to strengthen community-based rehabilitation for people with disabilities, advocate for appropriate care and subsistence of persons with disabilities, provide an allowance for carers for persons with complete and severe impairment, digitise the identity system for persons with disabilities, make public communication systems more disability-friendly, and strengthen the system of long-term care and rehabilitation at the provincial level for persons with severe disability.

⁴ Clause 33.

2.5.6 Rights of Persons with Disabilities Act, 2017

This Act has replaced the Disabled Persons Welfare Act of 1982, and shifted from a welfare-based approach to a rights-based approach to disability. The Act has tried to incorporate the human rights protection standards included in the UN Convention on the Rights of the Persons with Disabilities; see text box. The Act provides for the health and reproductive rights of women and special rights for children with disabilities. It sets out the obligations of all levels of government, family members and guardians, medical doctors and the community, and upholds the dignity and respect of persons with disabilities.

The Act defines and classifies persons with disabilities, includes the issuance of an identity card from local governments and establishes a mechanism for recording information on persons with disabilities. It includes the provision to set up a rehabilitation fund.

The key provisions related to health rights and social security of persons with disabilities enshrined in the Act include⁵:

1. Free healthcare service for low income groups and free hospital care for specified diseases and assistive devices and required therapy services.
2. Free medicines for persons suffering from haemophilia.
3. Removing the barriers to access to hospitals for medical care.
4. Priority in access to quality health care services and reservation of 2 beds in hospitals with a capacity of 50-beds or more.
5. All measures to prevent impairment and measures to deliver preventive, disease control, curative care and all other medical care services to persons with disabilities.
6. Rehabilitation for persons with complete and severe disability, persons with disabilities who are extremely poor, and persons with intellectual/mental or psychosocial impairment.
7. Social security
 - a. Community housing with safety and health service facilities
 - b. Housing facility for children and people with disability who are destitute

Rights of the persons with disability included in the Rights of the Persons with Disability Act, 2017:

1. Equal opportunity to exercise their rights
2. Right to non-discrimination for all persons with disabilities
3. Right to community life
4. Right to protection
5. Right to participation
6. Right to participate in policy making
7. Right to organize
8. Right to participate in cultural life
9. Right to access to services, facilities and justice
10. Right to social security
11. Right to information
12. Right to mobility

Special rights of children and women with disabilities include:

1. Health and reproductive rights of women
2. Special right of children with disabilities

Classification of disabilities

The Rights of Persons with Disabilities Act, 2017 classified disabilities into 10 categories:

- Physical disability
- Vision-related disability
- Hearing disability
- Vision and hearing impaired
- Speech or language-related impairment
- Mental and psychosocial impairment
- Intellectual disability
- Hereditary Hemophilia
- Autism-related impairment
- Multiple disability

The Act defines four levels of severity of disability: complete, severe, moderate and mild.

⁵ Clause 19, 20, 28, 29, 30, 32, 35, 37, 45 and 47 of the Act.

- c. Life insurance, health insurance and accidental insurance
 - d. Medicines and essential assistive devices
 - e. Unemployment allowance, subsistence allowance and elderly allowance
 - f. Allowance for caregiver
 - g. Consideration for gender, age, economic and social diversity
8. Special service and facilities for persons with mental or psychosocial impairment for medication and counselling services along with rehabilitation and family reintegration measures.

2.5.7 Protection and Welfare of Persons with Disabilities Rules, 1994

The Government of Nepal is in the process of formulating the rules to execute the provision of the Rights of Persons with Disabilities Act, 2017. Until now, the Health Protection and Welfare of Person with Disability Rules, 1994 has provided the following protection:

1. Free medical examination in all hospitals.
2. Two free beds for persons with disabilities in government hospitals having 50-bed or greater capacity.
3. Free medical care for elderly and destitute persons with disabilities in government hospitals.
4. Government support to non-government hospitals providing free medical examination, free hospital beds or medical treatment to persons with disabilities.
5. Disability Service Fund to provide financial support for education, training, medical treatment and rehabilitation of persons with disabilities

2.5.8 Disability Management (Prevention, Treatment and Rehabilitation) Policy, Strategy and 10-Year Plan (2017-2026)

This is the strategic plan of the Ministry of Health and Population to realize the health rights of persons with disabilities. The objectives are:

1. To increase access to promotional health services, reproductive health programmes and health related information and communication (promotional, early detection/identification of disease/status, care, rehabilitation and other health services) of persons with disabilities.
2. To implement disability prevention and reduction-related health programmes in a coordinated and effective way.
3. To ensure the access of persons with disabilities to basic health services, need-based specialized health and rehabilitation services on an equal basis with the general population.
4. To expand early disability identification programme down to the community level.
5. To provide support to non-governmental organisations involved in disability management.

Key results to be achieved within the ten-plan year plan include:

1. Health policies and programmes will be disability inclusive.
2. All government hospitals will provide free surgery, and medicines that are used by persons with disability on a regular basis will be provided free of cost.
3. All therapy services, assistive devices and counselling services will be provided free by all district hospitals.
4. All village level health posts will provide early identification, management and referral services to persons with disabilities.

5. Health-related promotional and preventive programmes and information will be accessible to persons with disabilities.
6. Children with disabilities will have prioritized access on a special basis to all nutrition programmes and services.
7. All provincial level hospitals will provide specialized health services to persons with disabilities.
8. Women and children with disabilities will have priority in maternal and child health programme and services.
9. Disabilities caused by communicable, non-communicable diseases and neglected tropical diseases and injury/trauma will be reduced.
10. All physical infrastructure in all health facilities will be disability-friendly.
11. Necessary knowledge, skill and competence required for disability management will be enhanced in all health staff.

2.5.9 National Strategy for Reaching the Unreached (2016-2030)

The National Strategy for Reaching the Unreached includes the objective of increasing access to and use of basic health services for persons with disabilities. The strategy takes a '**twin track approach**' to ensure disability inclusive health services in Nepal in line with the constitutional provisions, health policy and strategy and legal framework for the protection and welfare of persons with disabilities. This includes:

- Mainstreaming disability inclusion through provision of disability accessible infrastructure, financial protection for persons with disabilities, and improving the capacity of health providers to deliver disability inclusive, quality health services.
- Targeted disability-specific services such as the establishment of rehabilitation units in referral hospitals, strengthening mental health institutions, and expanding the range of rehabilitation therapies available including counselling and physiotherapy.

2.5.10 Guideline for Accessible Physical Infrastructure and Communication Services for People with Disability, 2012

This guideline has made it mandatory to bring public infrastructure up to minimum standards to ensure accessibility of persons with disabilities to essential humanitarian services. The guideline made provision for disability-friendly and accessible public infrastructure, accessible public transport system with reasonable accommodation, accessible communication system, assistive mechanism for facilitated communication, access to and use of information in a dignified manner with respect to autonomy, and access to entertainment facilities.

2.5.11 Standard Operating Procedure for Operation of Disability-Related Information and Help Desk, 2014

This document sets out the standard operating procedure for the establishment and operation of an information and help desk to provide basic support services to persons with disabilities. The standard operating procedure also applies to non-government agencies working at the district and local levels. It defines the support services to be provided to persons with disabilities including information on health facilities, free supply of assistive devices, acquisition of disability identity card and its use, as well as other health related services and facilities. The disability help desk should be equipped with information and documentation to meet the information needs of people with disabilities.

Chapter 3 Guidelines on Disability Inclusive Health Services

3.1 Preamble

The Ministry of Health and Population, Government of Nepal in line with the Constitution of Nepal and the Rights of the Persons with Disabilities Act, 2017

Recalling the constitutional and legal obligations, need for non-discrimination, dignity and respect to persons with disabilities which recognize the health rights of persons with disabilities and which sets up the foundation of human development,

Recognizing that disability is an evolving issue of humanity and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others,

Emphasizing the need to adopt the strategies of mainstreaming disability in the health service delivery system and effectively targeting health service delivery to persons with disabilities with the required capacity and willingness,

Recognizing the need to realize the effective management of disability prevention, healthcare services to persons with disabilities, health promotion for persons with disabilities and rehabilitation services in an integrated way as envisaged by the health policy and strategies along with the plan of action of the country,

Realizing and emphasizing the need to cater effective delivery of integrated health services to persons with disabilities in a responsive and inclusive way with accountability and broad-based collaboration and partnerships,

Recognizing that children, women and girls, and elderly people with disabilities may experience additional and intersectional risks of exclusion such as violence, abuse and exploitation and *realizing* the need to respond in an inclusive way,

Has put into force as follows:

3.2 Introduction

3.2.1 Short title and commencement:

- a. These guidelines may be called as the “**National Guidelines on Disability Inclusive Health Services, 2019**”, hereinafter mentioned as ‘guidelines’.
- b. These guidelines shall come into force immediately.

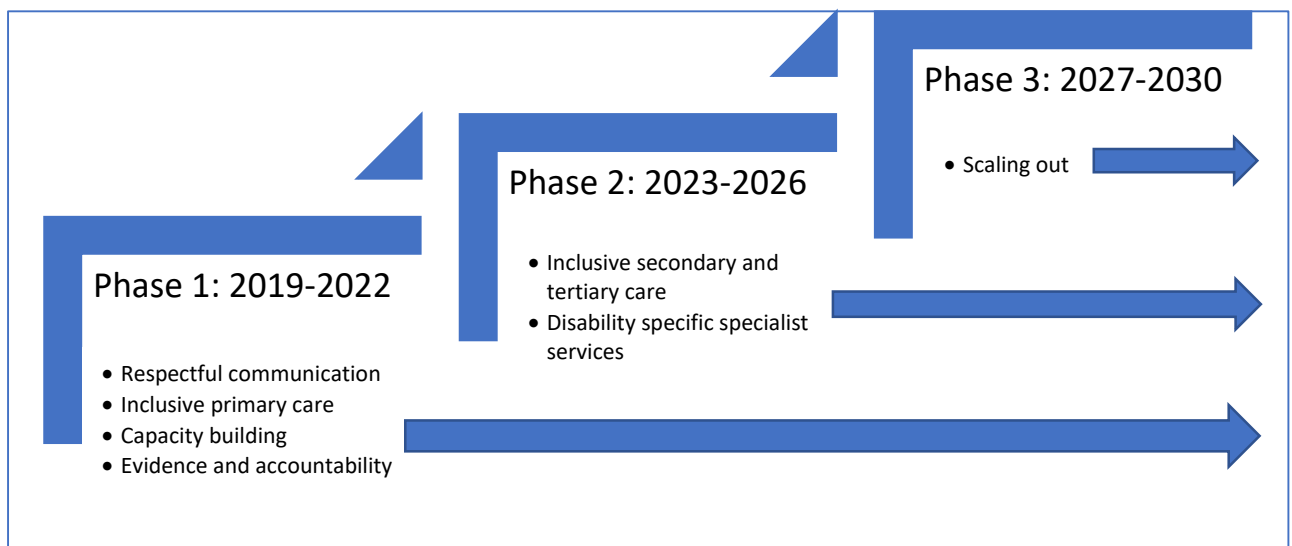
3.3 Phased approach

In recognition of the fundamental changes required in society to realise the rights of persons with disabilities and the institutional and capacity constraints of the health system, the guidelines take a progressive approach to realise disability inclusive health services. The timeframe of the guidelines is 2019 to 2030.

- **Phase 1** from 2019-2022 focuses on establishing the foundations for disability inclusion. The priorities are capacity building to promote respectful communication and inclusive primary health care service delivery and strengthening the evidence base for greater accountability. Actions in Phase 1 will continue through to 2030.
- **Phase 2** from 2023 to 2026 places a sharper focus on disability inclusion in secondary and tertiary care and strengthening of disability specific specialist services.
- **Phase 3** from 2027 to 2030 scales up actions shown to be working well and within the capacity of the health system.

The phased approach recognises the importance of strengthening the evidence base to measure results and apply learning to address gaps and adjust plans to the changing social and institutional context. Evidence of progress and performance will therefore be used to sharpen priorities and interventions as the guidelines are implemented across the country.

Figure 2: Phased approach towards disability inclusive health services



The guidelines in this chapter are structured into three main sections related to:

- a. Good practices for disability inclusion across all levels of health services
 - i. Respect, dignity and non-discrimination
 - ii. Inclusive information and communication
 - iii. Structural accommodations
- b. Delivery of disability inclusive health services
 - i. Disability inclusive basic health services
 - ii. Wellness and facilitation
 - iii. Medical care, follow up and referral of persons with disabilities
 - iv. Rehabilitation services
 - v. Sexual and reproductive health services
- c. Strengthening health systems to support the delivery of disability inclusive health services
 - i. Social health insurance
 - ii. Capacity building of human resources
 - iii. Information systems and evidence

iv. Accountability

3.4 Good practices for disability inclusion across all levels of health services

3.4.1 Respect, dignity and non-discrimination

To address harmful attitudes and behaviours towards persons with disabilities, health service providers at all levels of the system will provide respectful, dignified and non-discriminatory services to persons with disabilities. From Phase 1, all health service providers and health staff at all levels will:

- a. Respect the dignity of all persons with disabilities regardless of their impairment, gender, age, socio-economic status, caste/ethnicity, religion or other background characteristic, and respect their equality with others.
- b. Treat all persons with dignity, respect, empathy and compassion. Health professionals will be empathetic to the individual communication and behaviour characteristics and potential vulnerabilities of persons with disabilities (for example being a child, survivor of gender-based violence, older person) when providing respectful and professional care.
- c. Support persons with disabilities in their efforts to achieve an independent life and self-determination, and consider the aspects of power and dependence in the patient's relationships.
- d. Recognize the health rights of persons with disabilities to self-determination and respect their autonomy to decide and actively engage in promoting their well-being and health care. In situations where the person is unable to make independent health care decisions:
 - i. For children with disability who are under the age of 18, provide parents, guardians or care givers necessary information and advice for them to take decisions on behalf of their child.
 - ii. In the case of adults who are unable to make independent decisions regarding health services (for example those with intellectual disabilities) provide the necessary information and advice for their parents, guardians or care givers to make respective decisions. In the event that parents, guardians or care givers are not available, health providers should apply the 'do no harm' principle and seek authorisation from the authorised body such as the police and local government.
- e. Respect the right of persons with disabilities to equitable access to general health services as others. Provide the same range and quality of health services to persons with disabilities on an equal basis with others and ensure the provision of free healthcare care as eligible under the Constitution and the Rights of Persons with Disability Act, 2017 (see paragraph 2.5.6). Local governments may add to the entitlements to subsidised care, medicines and assistive devices provided to persons with disability.

Phased approach

Guidelines on respect, dignity and non-discrimination will be rolled out by all health service providers at all levels (primary, secondary, tertiary) from Phase 1 continuously.

3.4.2 Inclusive information and communication

To remove information and communication barriers and empower persons with disabilities to make informed health choices, health service providers at all levels unless otherwise stated will:

- a. Use respectful and non-discriminatory language in all interactions with, and discussions about persons with disabilities including at the point of contact with persons with disabilities in the community, health promotion activities, screening and prevention, registration in a health facility, assessment and diagnosis, treatment, discharge, follow-up, referral and rehabilitation. This includes the use of people-first language to overcome sub-conscious discrimination and which focuses the health care provider on the person and not the condition they may have.

Figure 3: Respectful and non-discriminatory verbal and body language

Respectful and dignified verbal and body language	Disrespectful language and body language
Person with intellectual disabilities or persons with learning disabilities	Mentally handicapped or retarded
Person who is blind, person who has low vision; partially sighted person	The blind; the visually impaired
Person who is deaf, person who is hard of hearing; a deaf person, a deaf-blind person	Suffers from hearing loss, the deaf, deaf and dumb, deaf-mute
Person who has multiple sclerosis	Afflicted by MS, victim of
Person with epilepsy	Epileptic
Person who uses a wheelchair	Confined or restricted to a wheelchair, wheelchair bound
Person with a physical disability	Invalid; handicapped person; cripple, crippled, lame
Unable to speak, uses synthetic speech	Dumb, mute
Seizure	Fit
Lives with/has/experiences a disability/impairment	Suffers from
Congenital disability, born with an impairment	Birth defect
Person who had polio, person with post-polio paralysis	Post-polio, suffered from polio
Accessible toilet/parking for persons with disabilities	Disabled toilet/handicapped parking
People living in poverty	'The poor'
People living in situations of vulnerability/people living in situations that make them more vulnerable to...	Vulnerable people/groups (although the UN use the term vulnerable groups)
Low income countries	Underdeveloped
Developing countries	Third world
Use gender neutral language such as referring to a person by their role rather than their gender: e.g. 'A doctor was running the hospital.'	Gender information unless necessary: e.g. 'A woman doctor was running the hospital'
Language which shows respect for local context and the challenges of individual situations such as: 'Kapil's family	Language of blame such as: 'Kapil's family didn't care about him and so didn't send him to school'

had not been told there was a way that they could help Kapil to go to school'	
Making eye contact with the client	Avoiding eye contact
Compassionate and professional physical contact with the client	Avoiding physically touching the client
Give extra time and patience in listening to clients with stuttering and stammering	Impatient and rushed care

- b. Make communication and information-sharing between health service providers and persons with disabilities accessible and respectful by using appropriate language, communication tools and materials. For all patients, use simple language, speak slowly and clearly, and maintain eye contact. Describe medical measures and procedures practically by showing instruments to be used. Provide clear and complete written diagnosis, treatment instructions, follow up and referral to the patient in addition to conveying verbally. Make use of audio-visual methods, easy-to-read formats, pictorial representations, use of Braille, and sign language.
- c. Health service providers coordinate with National Health Information Education and Communication Centre (NHIECC) on the design, testing and production of accessible health promotion and communication materials. This will include for example:
 - i. Health promotion materials translated into Braille for persons who have vision impairment.
 - ii. Audio materials for persons who have vision impairment.
 - iii. Visual materials for persons who have hearing impairment.
 - iv. Pictorial materials that are easy to understand for everyone and especially helpful for persons with intellectual disabilities, low vision and persons who have hearing impairment.
 - v. Easy to read materials in simple language and bold font for persons with low vision.
- d. The health service provider will collaborate with disabled people's organisations (DPOs) and other relevant organisations to strengthen communication and information sharing with persons with disabilities.
- e. Where appropriate, and respecting the rights and dignity of service users, support from family member or other caregiver may be used to facilitate communication between users and healthcare staff.
- f. In tertiary hospitals and rehabilitation units, provide electronic devices or Braille information boards on the right-hand side of the door indicating the floor and room number and any other important service delivery information for persons with vision-related impairment.

Phased approach

Guidelines on the roll out of inclusive information and communication will be rolled out as per the table below; this includes actions that are discussed in more detail in later sections of this guidelines. Actions initiated in Phase 1 and Phase 2 will continue through to 2030.

Figure 4: Roll out of inclusive information and communication

	Primary level	Secondary level	Tertiary level
Phase 1	<p>Use respectful and dignified body and verbal language as described in 3.4.2.a and 3.4.2.b</p> <p>Health service providers and NHEICC develop and make available at the health facility accessible health promotion and communication materials as described in 3.4.2.c</p> <p>Target persons with disability in community level health promotion and prevention activities as described in 3.5.1d</p> <p>Focal Person will call upon sign language interpreters to assist patients with hearing impairment as required as described in 3.5.1.h</p>	<p>Use respectful and dignified body and verbal language as described in 3.4.2.a and 3.4.2.b</p> <p>Health service providers and NHEICC develop and make available at the health facility accessible health promotion and communication materials as described in 3.4.2.c</p> <p>SSU or Focal Person provide information to persons with disabilities on health rights and availability of resources as described in 3.5.2.b</p> <p>SSU provide public and hospital-based information on rights of persons with disabilities as described in 3.5.2.h</p> <p>Focal Person or SSU hire sign language interpreter as required as described in 3.5.3.c</p>	<p>Use respectful and dignified body and verbal language as described in 3.4.2.a and 3.4.2.b</p> <p>Health service providers and NHEICC develop and make available at the health facility accessible health promotion and communication materials as described in 3.4.2.c</p> <p>Braille information boards or electronic devices indicating important information as described in 3.4.2.f</p> <p>SSU provide information to persons with disabilities on health rights and availability of resources as described in 3.5.2.b</p> <p>SSU provide public and hospital-based information on rights of persons with disabilities as described in 3.5.2.h</p> <p>SSU hire sign language interpreter as required as described in 3.5.3.c</p>
Phase 2		<p>SSU staff facilitate the interaction and communication between persons with disabilities and health care staff as described in 3.5.2.f</p> <p>Hospital develops capacity among staff in sign language as described in 3.5.3.c</p>	<p>SSU staff facilitate the interaction and communication between persons with disabilities and health care staff as described in 3.5.2.f</p> <p>Hospital develops capacity among staff in sign language as described in 3.5.3.c</p>
Phase 3			<p>Hospitals develop staff capacity in touch and sign skills as described in 3.6.2.c</p>

3.4.3 Structural accommodations

To enable persons with disabilities to overcome physical barriers to accessing and using health facilities, all health service providers will:

- a. Follow the national standard guidelines for design and construction of health building infrastructure when constructing new infrastructure, and progressively retro-fit existing health facilities⁶. This will include:
 - i. Accessible entries including the construction of access ramps, curb cuts etc
 - ii. Accessible pathways and parking space
 - iii. Safe crossings across the street
 - iv. Accessible toilets and signage for accessible toilets
 - v. Multilingual signage
 - vi. Lift in hospitals
 - vii. Provision of adjustable furniture such as beds and information desks (e.g. of variable heights, alternative formats). The delivery room and labour bed in primary health care centres and hospitals will be made accessible to persons with disability.
 - viii. Provide dedicated space in the waiting area of a health facility to accommodate the needs of persons with disabilities.

- b. Health facility and hospital management will assess the gaps in physical infrastructure and plan for retro-fitting.

Phased approach

Guidelines on the roll out of structural accommodations will be rolled out as per the table below.

Figure 5: Roll out of guidelines on structural accommodations

	Primary level	Secondary level	Tertiary level
Phase 1, Phase 2 and Phase 3	New buildings to comply with national standards guideline to ensure physical accessibility of persons with disabilities as described in 3.4.3.a Progressive retrofitting of existing buildings to comply with national standards guideline to ensure physical accessibility of persons with disabilities as described in 3.4.3.a	New buildings to comply with national standards guideline to ensure physical accessibility of persons with disabilities as described in 3.4.3.a Progressive retrofitting of existing buildings to comply with national standards guideline to ensure physical accessibility of persons with disabilities as described in 3.4.3.a	New buildings to comply with national standards guideline to ensure physical accessibility of persons with disabilities as described in 3.4.3.a Progressive retrofitting of existing buildings to comply with national standards guideline to ensure physical accessibility of persons with disabilities as described in 3.4.3.a

3.5 Delivery of disability inclusive health services

Health service providers will ensure persons with disabilities have access to health services on an equal basis with others at the primary, secondary and tertiary level. They will also progressively strengthen health services at each level to meet the specific health needs of persons with disabilities. Consideration will be given to developing model disability inclusive health services in existing health facilities and hospitals to demonstrate and share learning on how disability can be integrated across the health system.

⁶ Ministry of Health and Population. 2015. Standards Guidelines for Design and Construction of Health Building Infrastructure.

3.5.1 Disability inclusive primary health care services

To ensure persons with disabilities have access to primary health care services on an equal basis with others, health service providers at the local level will make necessary accommodations, work with local disabled people's organisations and build the capacity of primary health care providers. In addition to good practice actions described in section 3.4 above, health service providers will in Phase 1:

- a. Assign the in-charge of the health facility (Primary Health Care Centre, Health Post, Community Health Unit and Urban Health Centre) as the Focal Person for disability inclusion. The Focal Person will be responsible for:
 - i. Leading the integration of disability inclusion in the functioning of the facility and provision of services.
 - ii. Coordinating with local government for funds to cover the transport costs of persons with disability and their care giver to reach medical and rehabilitation care.
 - iii. Agreeing with the local government and referral hospitals the referral pathway for patients with disabilities that need higher level care.
 - iv. Identifying and maintaining a list of sign language interpreters that can be called upon as required by individual clients.
- b. Map and create a profile of each person with disabilities in the service catchment area including their individual functional limitations and impairments; see Annex 2. Mapping and profiling will be the responsibility of the local governments in coordination with Focal Person, local DPOs and community-based rehabilitation programmes. It will include persons with Disability Identification Card and those who are yet to receive such a card. Disability Identification Cards are colour coded as red for persons with complete disability, blue for persons with severe disability, yellow for persons with moderate disability and white for persons with mild disability.
- c. The mapping and profiling exercise will give health providers opportunity to engage with persons with disabilities in the catchment area and provide them with essential health information. It will also assist health providers in planning how to accommodate the needs of persons with disabilities in the delivery of primary health services.
- d. Ensure persons with disabilities in the catchment area are included in health promotion and prevention activities undertaken by health staff and community-based health volunteers and are aware of the availability of local health services and the resources provided by local government for persons with disabilities. Where necessary provide home-based services if the person is unable to attend the health facility or community site. Collaborate and partner with disabled people's organisations and community-based rehabilitation programmes to maximise participation of persons with disabilities wherever possible.
- e. Strengthen early identification of high-risk parents during antenatal care and refer if necessary for counselling and possible testing to central level hospitals. During postnatal care, such as at the time of vaccination, children with a positive screening (e.g. for physical or other impairment) will be identified and referred for the appropriate medical support. Health staff

are to provide families in particular mothers, with psychological and practical support if their child is referred for testing and counselling. Health staff to refer persons with disability who have health problems that cannot be managed at the primary level to the appropriate hospital.

- f. Raise awareness and generate community support for the rights of persons with disabilities in partnership with local government bodies, schools, community organisations and disabled people's organisations.
- g. Local governments will include activities for disability inclusion in all health programmes in the annual workplan and budget (AWPB). This includes mapping and profiling of persons with disability, targeted health promotion and awareness raising including additional outreach and home visits, assistive devices, physiotherapy, structural accommodations necessary for physical and financial access to health services. Local governments will coordinate with and seek assistance from disabled people's organisations, community-based rehabilitation programmes and other agencies when developing the AWPB.

Phased approach

Guidelines on disability inclusive primary health care services will be rolled out by all health service providers at primary level from Phase 1 onwards and continue.

3.5.2 Delivery of wellness support and facilitation to persons with disabilities at hospitals

To provide wellness support to persons with disabilities and facilitate their access to quality health services at the hospital level, health service providers will integrate a wellness function within hospital Social Service Units (SSU) as they are scaled up across the country. Social Service Units will become available at all public hospitals above previously named district hospitals. Where there is no SSU the hospital will appoint a Focal Person for disability inclusion. Specifically:

- a. Social Service Unit will provide wellness support services for all persons with disabilities. The wellness service will support the physical, psychological and emotional wellness of persons with disabilities during their visit to the hospital.
- b. Social Service Unit will provide information on the health rights of persons with disabilities, the resources and assistance available at the hospital for patients, their families and caregivers, and other local resources and organisations they can access outside of the hospital. Where Social Service Units are not established a more limited information sharing and facilitation role will be provided by the Focal Person.
- c. The SSU will coordinate with local government for the provision of funds to cover the transport costs of persons with disabilities and their caregiver if this has not already been provided or they are referred to another hospital or rehabilitation centre.
- d. The Social Service Unit will be charged with responsibility for advising the Hospital Development Board/Hospital Management Committee on, and monitoring, structural

accommodations necessary for the safe physical access of all persons with disability to use hospital services.

- e. Staff in the Social Service Unit will help persons with disabilities navigate hospital services and access the care they need and have a right to, in a dignified and inclusive manner. This may include accompanying the patient during history taking, clinical examination and investigations if requested by the patient. As the capacity of SSU staff to understand the needs of persons with disabilities and assist them in communicating with health care staff increases, they will play a stronger facilitation role between the patient and the health care staff.
- f. All hospitals are to use the existing fast track they have for patients classified with complete and severe disability. If a person with disabilities approaches the SSU without an official disability identification card, then the Social Service Unit may provide them subsidised services as they fall under the SSU target group population. In this case, a medical doctor will be requested to assess the patient and if an impairment is confirmed, they will recommend to the local government that the person qualifies for a Disability Identification Card. Where there is no SSU the Focal Person will recommend the patient receives free and subsidised care to the Hospital Director and advise the patient to approach the local government for advice on how to apply for a Disability Identification Card.
- g. The Social Service Unit will integrate public awareness raising of the health rights of persons with disabilities as part of their information, education and communication function in the community and in the hospital.
- h. The Hospital Development Committee/Hospital Management Committee and the Social Service Unit will forge collaborative relationships with provincial and local governments, disabled people’s organisations, local civil society organisations including NGOs and universities, and the private sector to leverage financial and non-financial support to assist the hospital meet the health needs and rights of persons with disabilities. Where there is no SSU, the hospital management will forge collaborative relationships with the organisations mentioned.

Phased approach

Guidelines on wellness support and facilitation will be rolled out as per the table below. Actions initiated in Phase 1 and Phase 2 will continue through to 2030.

Figure 6: Roll out of wellness support and facilitation

	Primary level	Secondary level	Tertiary level
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Phase 1		<p>Where existing SSU, provision of wellness services as described in 3.5.2.a</p> <p>In hospitals without SSU, Focal Person to be appointed to facilitate access to services for persons with disabilities as described in 3.5.2.b</p> <p>In hospitals with SSU</p> <ul style="list-style-type: none"> • SSU to coordinate with local government on transport costs for persons with disabilities as described in 3.5.2.c • SSU staff help persons with disabilities navigate hospital services as described in 3.5.2.e • SSU facilitate subsidised care of persons with disabilities without a Disability Identification Card as described in 3.5.2.f • SSU facilitate persons with disabilities without a Disability Identification Card to apply for an official card as described in 3.5.2.f • SSU will monitor and advise management on the physical accessibility of the hospital as described in 3.5.2.d <p>Focal Person facilitate subsidised care of persons with disabilities without a Disability Identification Card in hospitals without SSU as described in 3.5.2.f</p> <p>All hospitals to use fast track for persons with complete and severe disability as described in 3.5.2.f</p> <p>Hospital management to collaborate with external organisations to seek support for wellness services as described in 3.5.2.h</p>	<p>Existing and new SSUs to provide wellness services as described in 3.5.2.a</p> <p>SSU to:</p> <ul style="list-style-type: none"> • SSU to coordinate with local government on transport costs for persons with disabilities as described in 3.5.2.c • SSU staff help persons with disabilities navigate hospital services as described in 3.5.2.e • SSU facilitate subsidised care of persons with disabilities without a Disability Identification Card as described in 3.5.2.f • SSU facilitate persons with disabilities without a Disability Identification Card to apply for an official card as described in 3.5.2.f • SSU will monitor and advise management on the physical accessibility of the hospital as described in 3.5.2.d <p>All hospitals to use fast track for persons with complete and severe disability as described in 3.5.2. f</p> <p>Hospital management to collaborate with external organisations to seek support for wellness services as described in 3.5.2.h</p>
Phase 2		New SSUs established and provide wellness services as described in 3.5.2	
Phase 3		New SSUs established and provide wellness services as described in 3.5.2	

3.5.3 Disability inclusive medical care, referral and follow up

To ensure medical care and treatment is disability inclusive and responds to the specific disability related health needs of persons with disabilities, health service providers will:

- a. Make all aspects of healthcare (including examination, treatment and interventions) for persons with disabilities available in a safe, accessible, dignified and inclusive manner on an equal basis with others.

- b. Provide all counselling services, tests, drugs, therapies and assistive devices free of cost to persons with disabilities as per Constitution 2015 and Rights of Persons with Disabilities Act, 2017; described in 3.4.1.e. Health facility and hospital management will coordinate with local government to create a special fund for free health care services for persons with disabilities as per the authority of the local government and unbundling of functional responsibility given under the Constitution.
- c. Medical staff will be responsible for providing full information about the treatment for patients with disabilities, including any prescribed medications, out-patient appointments, referral, rehabilitation including physiotherapy and assistive devices, using language and communication methods appropriate to the needs of the patient. Medical staff may take assistance from the Social Service Unit personnel if present in the health facility to help convey information to the patient in an accessible way such as tactile and sign communication. External support to provide sign language assistance may be hired by the hospital or SSU as required by individual patients. Hospitals are encouraged to progressively develop capacity of selected staff in sign language. The SSU or Focal Person in the hospital will maintain a list of local sign language interpreters that can be called upon.
- d. Hospital management to establish a mechanism to refer patients with disabilities to specialists within the hospital as well as specialist and rehabilitation services outside of the hospital.
- e. The Social Service Unit where established or Focal Person will be responsible for monitoring and facilitating referral. The SSU or Focal Person will maintain contact with referral and rehabilitation facilities.
- f. Make all routine tests available for persons with disabilities in PHCC and above. Additional specialist tests will be available at provincial and tertiary level.
- g. SSU to inform patients with complete and severe disabilities of follow up appointments at least a day prior to the scheduled consultation.
- h. Following appropriate assessment by a qualified medical professional, assistive devices will be provided free of cost, including wheelchairs, crutches, walking sticks and canes, prosthesis spectacles, magnifying glasses, white canes, screen-readers, Braille displays, and hearing aids etc as per the government's priority list of assistive devices; see Annex 1. Hospitals will seek assistance from local governments, private and charitable organisations to meet the cost of covering assistive devices.
- i. Tertiary and secondary hospitals will be strengthened to provide specialist services to meet the specific health needs of persons with disabilities including assessment, diagnosis, treatment and rehabilitation. This will be undertaken progressively over the three phases of rolling out these guidelines:

- i. Formation of a specialist multidisciplinary team for identification of disabilities, and provision of multidisciplinary care and support will be undertaken in tertiary hospitals in Phase 1 and secondary hospitals in Phase 2 and Phase 3.
- ii. ENT doctors and audiology services will be strengthened in tertiary and secondary hospitals during Phase 1.
- iii. Speech and language therapy services to diagnose, assess and provide support, including augmented communication for persons with speech and language-related disabilities will be provided in tertiary hospitals in Phase 1 and secondary hospitals in Phase 2 and Phase 3.
- iv. Psychiatric assessment, care and provision of free drugs for those with acute or long-term mental illness will be progressively strengthened so that these services are available in tertiary in Phase 1 and secondary hospitals in Phase 2 and Phase 3.
- v. A haemophilia unit will be established in a tertiary hospital during Phase 1 and selected secondary hospitals in Phase 2 and Phase 3.
- vi. Early detection and treatment services to children and adults with intellectual impairments (including autism, Down syndrome) will be provided in at least one tertiary hospital in Phase 1 and selected secondary hospitals in Phase 2 and Phase 3.
- vii. For persons with ‘multiple disabilities’, assessment and provision of assistive devices will be available at tertiary hospitals in Phase 1 and selected secondary hospitals in Phase 2 and Phase 3.

Phased approach

Guidelines on the roll out of disability inclusive medical care, referral and follow up will be rolled out as per the table below. Once actions are initiated they will continue to 2030.

Figure 7: Roll out of disability inclusive medical care, referral and follow up

	Primary level	Secondary level	Tertiary level
Phase 1	Referral to secondary and tertiary hospitals as described in 3.5.1.e Routine tests available as described in 3.5.3.f	Make all aspects of health care available in a safe and dignified manner as described in 3.5.3.a Provide free and subsidised services to persons with disabilities as described in 3.4.1.e. Referral mechanism within and to external hospitals and rehabilitation centres established as described in 3.5.3.d SSU monitors and facilitates referral as described in 3.5.3.e. Where no SSU, Focal Person facilitates referral. Special tests available for persons with disabilities as described in 3.5.3.f SSU inform patients with disabilities about follow up appointments as described in 3.5.3.g	Make all aspects of health care available in a safe and dignified manner as described in 3.5.3.a Provide free and subsidised services to persons with disabilities as described in 3.4.1.e. Referral mechanism within and to external hospitals and rehabilitation centres established as described in 3.5.3.d SSU monitors and facilitates referral as described in 3.5.3.e Specialist tests available for persons with disabilities as described in 3.5.3.f SSU inform patients with disabilities about follow up appointments as described in 3.5.3.g

		<p>Provision of assistive devices as described in 3.5.3.h</p> <p>Medicines used on a long-term basis by persons with disabilities to be provided free as described in 3.4.1.e</p> <p>ENT and audiology services strengthened as in 3.5.3.i.b</p>	<p>Provision of assistive devices as described in 3.5.3.h</p> <p>Medicines used on a long-term basis by persons with disabilities to be provided free as described in 3.4.1.e</p> <p>Specialist multidisciplinary team for identification of disabilities, and provision of multidisciplinary care as described in 3.5.3.i.a</p> <p>ENT and audiology services strengthened as in 3.5.3.i.b</p> <p>Speech and language services strengthened as in 3.5.3.i.c</p> <p>Psychiatric services strengthened as in 3.5.3.i.d</p> <p>Haemophilia unit established as in 3.5.3.i.e</p> <p>Services for persons with intellectual impairments as described in 3.5.3.i.f</p> <p>Services for persons with multiple disabilities as described in 3.5.3.i.g</p>
Phase 2		<p>Specialist multidisciplinary team for identification of disabilities, and provision of multidisciplinary care as described in 3.5.3.i.a</p> <p>Speech and language services strengthened as in 3.5.3.i.c</p> <p>Psychiatric services strengthened as in 3.5.3.i.d</p> <p>Haemophilia unit established as in 3.5.3.i.e</p> <p>Services for persons with intellectual impairments as described in 3.5.3.i.f</p> <p>Services for persons with multiple disabilities as described in 3.5.3.i.g</p>	
Phase 3		<p>Specialist multidisciplinary team for identification of disabilities, and provision of multidisciplinary care as described in 3.5.3.i.a</p> <p>Speech and language services strengthened as in 3.5.3.i.c</p> <p>Psychiatric services strengthened as in 3.5.3.i.d</p> <p>Haemophilia unit established as in 3.5.3.i.e</p>	

		Services for persons with intellectual impairments as described in 3.5.3.i.f	
		Services for persons with multiple disabilities as described in 3.5.3.i.g	

3.5.4 Rehabilitation Services

National and subnational governments will progressively strengthen the provision of rehabilitation services from its current low base in Nepal. This will include:

- a. Ministry of Health and Population in coordination with Ministry of Women, Children and Senior Citizens and disabled people’s organisations will undertake a mapping and profiling of existing rehabilitation centres related with different types of disabilities and their services throughout the country. This information will be provided to health service providers, Social Service Units, local governments, disabled people’s organisations, community organisations and NGOs working in the field of disability and rehabilitation.
- b. At the primary health care level in Phase 1:
 - i. Local governments will enter into a Memorandum of Understanding with local rehabilitation centre(s) for the care of persons who need in-patient rehabilitation services.
 - ii. The health facility Focal Person will coordinate with local government and community- based rehabilitation programmes to support community-based rehabilitation.
 - iii. Assistive devices will be made available to health facilities and rehabilitation centres by the local government in coordination with NGOs and INGOs.
- c. At secondary and tertiary hospitals in Phase 1
 - i. Hospital Development Board/Hospital Management Comment will explore partnership arrangements including public-private partnership for strengthening provision of rehabilitation services for prevention and management of disability. Such arrangements will strengthen referral linkages between hospitals and rehabilitation centres.
 - ii. Secondary and tertiary hospitals and rehabilitation centres will provide assistive devices to patients as per government guidelines following an appropriate assessment and referral by trained medical professional. See Annex 1 for a priority list of government approved assistive devices. This includes introduction of augmentative and alternative communication devices for persons with hearing impairment.
 - iii. Rehabilitation units/centres will provide “step-down facility” or interim care for medically stable patients while preparing them for discharge into the community.
- d. At secondary and tertiary hospitals in Phase 2 and Phase 3
 - i. Minimum standards of medical rehabilitation services will be defined for all hospitals and independent rehabilitation centres by Ministry of Health and Population.

- ii. Rehabilitation medicine services will be provided by a medical rehabilitation team including physiatrist or rehabilitation physician, rehab nurse, occupational therapist, physiotherapist, psychologist, prosthetist and orthotist, and social worker. This will be provided at tertiary hospitals in Phase 2 and selected secondary hospitals in Phase 3.

Phased approach

Guidelines on rehabilitation services will be rolled out as per the table below. Once actions are initiated they will continue.

Figure 8: Roll out of rehabilitation services

	Primary level	Secondary level	Tertiary level
Phase 1	<p>Mapping of rehabilitation services available by Ministry of Health and Population and Ministry of Women, Children and Senior Citizens</p> <p>MoU with rehabilitation centres as described in 3.5.4.b</p> <p>Focal Person coordinate on community-based rehabilitation as described in 3.5.4.b</p> <p>Assistive devices available as described in 3.5.4.b</p>	<p>Mapping of rehabilitation services available by Ministry of Health and Population and Ministry of Women, Children and Senior Citizens</p> <p>Partnership arrangements to strengthen rehabilitation services as described in 3.5.4.c</p> <p>Assistive devices provided as described in 3.5.4.c</p> <p>Step down facility in rehabilitation units/centres as described 3.5.4.c</p>	<p>Mapping of rehabilitation services available by Ministry of Health and Population and Ministry of Women, Children and Senior Citizens</p> <p>Partnership arrangements to strengthen rehabilitation services as described in 3.5.4.c</p> <p>Assistive devices provided as described in 3.5.4.c</p> <p>Step down facility in rehabilitation units/centres as described 3.5.4.c</p>
Phase 2		<p>Minimum standards of medical rehabilitation services defined as described in 3.5.4.d</p>	<p>Minimum standards of medical rehabilitation services defined as described in 3.5.4.d</p> <p>Rehabilitation medicine services as described in 3.5.4.d</p>
Phase 3		<p>Rehabilitation medicine services as described in 3.5.4.d</p>	

3.5.5 Disability inclusive sexual and reproductive health services

All health service providers will ensure that the sexual and reproductive health needs and rights of persons with disabilities including those of older persons are integrated into existing programmes and service delivery at each level of service provision. To ensure that all sexual and reproductive health programmes reach and serve persons with disabilities in Phase 1:

- a. The capacity of health providers to recognise and respect the sexual and reproductive health needs and rights of persons with disabilities will be strengthened. This will include awareness of how to communicate and counsel in an inclusive and respectful manner to all persons, including those with disabilities.
- b. Raise awareness of persons with disabilities, including older people, of their sexual and reproductive health rights and availability of sexual and reproductive health services.

- c. Ministry of Health and Population will support research on the sexual and reproductive health of persons with disabilities to inform programming. It will foster knowledge networks with health service providers, other government departments, DPOs and civil society organisations to promote the sexual and reproductive health of persons with disabilities.

Phased approach

Guidelines on disability inclusive sexual and reproductive health services will be initiated in Phase 1 at all levels of health services and continue.

3.6 Health systems strengthening to support the delivery of disability inclusive health services

3.6.1 Disability inclusion in social health insurance

Ministry of Health and Population will ensure the interests and needs of persons with disability are included in coverage of social health insurance equal to others. As per the Rights of Persons with Disability Act, 2017, provision is made for contributory and government financed health insurance. Chapter 7, clause 32 provides for health insurance for persons with disabilities, insurance for providing assistive devices and medicines, and for funding the cost of caregivers.

3.6.2 Strengthening human resource capacity

To deliver disability inclusive health services, the capacity of the health workforce will be developed to mainstream disability into health services and to build capacity to provide disability-specific services. This will include:

- a. Integration of disability inclusive training in induction and in-service training provided by the National Health Training Centre and Provincial Health Training Centres.
- b. Capacity development of Social Service Unit staff to fulfil their wellness function. This will include strengthening psychosocial counselling, patient facilitation and interpersonal communication.
- c. LCDMS to coordinate with DPOs on developing capacity within health services to provide touch and sign language skills for persons with vision and hearing disability at each level of the health system.
- d. Hospital to review and periodically assess the human resource capacity to deliver disability inclusive services effectively and plan the progressive strengthening of human resources to achieve this with financial support of provincial and local governments.
- e. Local government to review and periodically assess the human resource capacity to deliver disability inclusive primary health services effectively and plan the progressive strengthening of human resources to achieve this with financing from local government.

Phased approach

Guidelines related to human resource capacity building will be initiated in Phase 1 and continued.

3.6.3 Provision of disability specific health services

The table below shows the minimum package of disability specific services to be available at each level of the health service.

Figure 9: Disability specific health services by health level

Level of Health Service Provider	Minimum services to be provided
Primary Hospital (upgraded Primary Health Care Centre) Health Post, Urban Health Centre/Clinic, Community Health Unit	<ol style="list-style-type: none"> 1. Mapping and profiling 2. Wellness support through Focal Person 3. First line of counselling and early detection/identification 4. Basic assessment 5. Assistive devices 6. Referral to hospitals for disability specific services 7. Networking with community-based rehabilitation programmes
Provincial Hospital (previously district, zonal and sub-regional hospital)	<ol style="list-style-type: none"> 1. Wellness support and facilitation through SSU if available 2. In selected hospitals, specialized medical treatment services with test and examination, and therapies 3. Assistive devices 4. Rehabilitation facilities in selected hospitals 5. Referral services 6. Networking with PHC and hospitals 7. Collaboration and partnerships with rehabilitation providers
Tertiary hospitals (central, specialised and academy hospitals)	<ol style="list-style-type: none"> 1. Wellness support and facilitation through SSU as the focal point 2. Specialized medical treatment services with test and examination, and therapies 3. Assistive devices 4. Rehabilitation facilities 5. Referral services 6. Networking with hospitals and PHC 7. Collaboration and partnerships with rehabilitation providers

3.6.4 Health information systems and evidence

There is a need to improve the evidence available on use of health services by persons with disabilities. This is necessary to improve the responsiveness of services delivered for individual clients, persons with disabilities as a disadvantaged population, and to measure and evaluate the progress made in meeting the rights of persons with disabilities as laid out in the Constitution and health policies.

- a. Hospital management integrate inclusion of patients with disabilities in existing hospital information management systems to support their health care management and hospital monitoring of services provided to patients with disabilities.
- b. Policy, Planning and Monitoring Division integrate disability-disaggregated indicators into selected indicators of the health management information system to enable a more evidence-based response to the health needs of persons with disabilities.
- c. Leprosy Control and Disability Management Section (LCDMS) under Epidemiology and Disease Control Division (EDCD) provide evidence-based support to disability inclusive programming and budgeting at all levels of the government.
- d. LCDMS support evidence gathering of the health care needs of persons with disabilities and their use of services through collaboration with disability people's organisations, community organisations, NGOs, and researchers. LCDMS will advocate for inclusion of internationally standardised disability indicators (Washington Short Group) ⁷in household surveys such as National Demographic and Health Survey, Nepal Health Facility Survey and Service Tracking Survey.

⁷ www.washingtongroup-disability.com/washington-group-question-sets/short-set-of-disability-questions/ Washington Short Group)

Phased approach

Roll out of the guidelines related to information systems and evidence will be initiated in Phase 1 and continued.

3.6.5 Accountability for disability inclusive quality health service delivery

Accountability for disability inclusive quality health service delivery will be achieved through various mechanism, this includes:

- a. Accountability for upholding the rights of persons with disabilities:
 - i. Hospital Development Board/Hospital Management Committee develop and execute a service charter to respect the rights of persons with disability in delivery of health services to persons with disabilities on an equal basis with others. The service charter will include specification of the rights of persons with disabilities, responsibilities of service providers to deliver inclusive services, grievances and complaints redressal mechanism and a system of compensatory justice.
 - ii. Local governments work with health service providers and civil society organisations to support annual social auditing of disability inclusive health services and respond to findings and recommendations accordingly.
 - iii. ECDC conduct regular monitoring and evaluation of the provision, access and quality of health services to persons with disabilities.
- b. Quality assurance and continuous quality improvement:
 - i. Hospital Development Board/Hospital Management Committee to introduce a quality assurance mechanism that sets quality standards for services provided to persons with disabilities and monitor performance.
 - ii. Health service providers to use evidence on the health care needs of persons with disabilities and their use of health services to contribute to the continuous improvement in the delivery of quality services.
 - iii. Hospital management form in-house quality circles to monitor, identify gaps and improve how disability inclusion is integrated into service delivery.
- c. Management for disability inclusion:
 - i. Hospital Development Boards/Hospital Management Committees collaborate with provincial and local governments to formulate and implement a capacity development plan to enhance management oversight of the delivery of disability inclusive health services.
- d. Coordination and partnership:
 - i. Gender Equality and Social Inclusion (GESI) institutional mechanisms (see chapter 4 for details) at the federal, provincial and local levels coordinate authority, resources and operating systems to achieve disability inclusive health service delivery.
 - ii. Health service providers establish partnerships with disabled people's organisations (DPOs) as policies and programmes are consistently better when DPOs take part in their development.

Phased approach

Guidelines related to accountability and coordination and partnership will be initiated in Phase 1 and continue. Actions related to quality assurance and management will be initiated in Phase 2 and continue.

Chapter 4 Implementation, Monitoring and Evaluation

4.1 Effective implementation of the guidelines

The following actions will be taken to enable the effective implementation of the guidelines:

- a. Secure high-level political and administrative commitment, support and cooperation from the MoHP for implementing the guidelines.
- b. Advocate and sensitise stakeholders on the objectives and scope of the guidelines.
- c. Activate and empower GESI committees at all levels of government to guide, coordinate, facilitate, monitor and evaluate implementation of the guidelines; see Annex 3 for GESI institutional structure. For human resource capacity enhancement, GESI Committee will coordinate with provincial and local governments, hospital management, health facility management, NHTC and PHTCs. Management of capacity enhancement will be the responsibility of hospital management and LCDMS of ECDC/DOHS.
- d. Carry out regular follow-up and review of implementation of the guidelines and integrate the review process with the periodic review of the plan and programme of the health sector.
- e. Strengthen the institutional capacity of the Leprosy Control and Disability Management Section of the DoHS to enable it to carry out coordination and facilitation of guidelines implementation and support its implementation, monitoring and evaluation and advocate for disability inclusion related reforms. The GESI Section of the MoHP will also be strengthened to coordinate and facilitate implementation of the guidelines.
- f. The institutional capacities of SSUs will be strengthened and extended down to secondary hospitals.
- g. Carry out continuous improvements in the guidelines by reviewing and evaluating the effectiveness of implementation.

4.2 Coordination and facilitation at central, provincial and local levels

This guideline shall be used as the guiding document for disability inclusive health service delivery at tertiary, secondary and primary levels. In line with the multi-level governance system enshrined in the Constitution, the following measures shall be adopted to coordinate and facilitate the realization of the guidelines at provincial and local levels:

- a. Sensitize and advocate for disability-inclusive health services and disability responsive health service management under the leadership of the GESI committees/mechanisms at provincial and local levels. Focal Persons at primary level health facilities and some secondary hospitals and SSUs at tertiary and secondary hospitals will facilitate delivery of disability inclusive health services.
- b. GESI Committees, provincial and local governments shall create an enabling environment for disability inclusion for the implementation of the guidelines.
- c. Develop information exchange network between the health sectors of the three tiers of government on experiences and achievements with respect to improvements in disability inclusive health service delivery.
- d. Provide necessary technical assistance and management support to the provincial and local levels by the Ministry in implementing the guidelines at hospitals and health facilities.

- e. Conduct disability inclusion social audit of the health service system at provincial and municipal levels and carry out measures for necessary reforms.

4.3 Collaboration and partnerships

- a. Promote collaboration and partnerships between different agencies, different levels of government, stakeholder groups, elected representatives, disabled people's organisations, civil society organisations, development partners, persons with disabilities and their families and communities.
- b. Management capacity of provincial and local governments, hospitals and health facilities shall be strengthened to build partnerships.
- c. Partnerships with academic institutions like medical colleges and paramedical institutions, and professional organisations will be fostered to seek volunteering and internship support and the use of interns to support the inclusion and mainstreaming of persons with disabilities. For this, the health service provider shall develop Memorandum of Understanding to ensure accountability and continuity.

4.4 Institutional arrangements for implementation of the guidelines

- a. The GESI Committee of the Ministry will be made responsible and capable to coordinate implementation of the guidelines at the federal, provincial and local levels.
- b. The LCDMS/EDCD of the Department of Health Services will be the principal technical agency to provide technical and managerial support for implementation of the guidelines.
- c. Ministry of Health and Population will be responsible for facilitating implementation of the guidelines at central and specialized hospitals.
- d. The provincial and local level hospital management committees will be made responsible for implementation of the guidelines at the health institutions of the respective levels.
- e. MoHP shall coordinate with the provincial government Provincial Health Directorate, Ministry of Social Development and the concerned local government to set up and capacitate the SSU in all provincial hospitals.
- f. The standard operating procedures of the SSU will be harmonized in line with the provisions of the guidelines.

4.5 Reform plan for implementation of the guidelines (2019 to 2030)

- a. Implementation of the guidelines will be undertaken in a phased and progressive approach given the scope of development, the institutional context, and human resource capacity of government health services.
- b. Effective health management for disability inclusion requires strengthening of four pillars:
 - i. Competent and adequate number of health staff with the capacity to provide disability inclusive health services
 - ii. Efficient and disability inclusive health service delivery
 - iii. Accountability for quality, disability inclusive health service delivery
 - iv. Collaboration and partnerships with organisations providing disability inclusive health and rehabilitation services, voice and resources for disability inclusion such as DPOs and civil society; and participation of persons with disabilities, their families and communities.



- c. The planned reform shall be supported by funding from the health sector annual programme and budgetary arrangements at all levels of government.

4.6 Evidence-based monitoring and evaluation

- a. The capacity of the LCDMS to review evidence and provide technical advice to health service providers and monitor implementation of the guidelines will be strengthened.
- b. Local mapping of persons with disability by primary level health service providers will provide information for primary health care service delivery and evidence-based planning and budgeting at the primary level.
- c. Integration of disability-disaggregated data for selected indicators in the existing HMIS will enable Ministry of Health and Population, provincial and local governments to monitor use of health services by persons with disabilities, identify gaps and strengthen planning and management.
- d. Integration of patients with disabilities in existing hospital information management systems will enable hospital management to monitor use of services by patients with disabilities, and strengthen responsive management.
- e. Disability related data collection shall be integrated in the National Demographic and Health Survey, Nepal Health Facility Survey and Service Tracking Survey, and other relevant surveys using standardised methods (Washington Short Group) to strengthen the evidence for policy, programme and system-related reforms.
- f. An independent audit of disability inclusion shall be undertaken by the Ministry of Health and Population every three years to identify evidence-based improvements to the Guidelines.

4.7 Action plan for implementation of the guidelines

S.No	Priority Actions	Responsible Agency	Time Line (Phases)			Monitoring Indicator
			First Phase (2019/20-2022/23)	Second Phase (2023/24-2025/26)	Third Phase (2026/27-2029/30)	
Orientation and mapping						
1.	Orientation and sharing of the guidelines to health service providers and health care staff	LCDMS/EDCD, provincial and local governments	√			Orientation on the guidelines at all levels
2.	Mapping and profiling of persons with disabilities	Local level health facilities	√	√	√	Health profile of all persons with disabilities completed
Structural accommodations						
3.	Plan and deliver retrofitting of health facilities and hospitals to meet standards of national building guidelines	MoHP, provincial and local governments, health facility management and hospital management	√	√	√	Physical access improvement plan implemented
Information and communication						
4.	Accessible health promotion and communication materials developed and provided to health facilities and hospitals	NHIECC, provincial and local governments, NHTC, PHTC	√	√	√	Materials produced and available at facility level
Service delivery						
5.	Disability inclusive primary health care service delivery	Local governments, health facility Focal Person	√	√	√	Utilisation of primary care services by persons with disabilities
6.	Health service fund for persons with disabilities set up by local government to provide financial support for medicines, assistive devices, transportation cost and the cost of caregiver	Health facility and hospital management committees in collaboration with local government		√	√	Health service fund for persons with disabilities set up
7.	Sexual and reproductive health services available for persons with disabilities	Health facility and hospital management committees	√	√	√	Sexual and reproductive health services delivered to

	in all health facilities and hospitals					persons with disabilities
8.	Wellness support and facilitation services in hospitals with existing and new SSUs	Hospital Management Committees, SSUs	√	√	√	Wellness support services made functional and used by persons with disabilities
9.	Disability inclusive medical care, referral and follow up	Hospital management, SSU	√	√	√	Utilisation of hospital services by persons with disabilities
10.	Specialist services for disability specific conditions at tertiary hospitals	Hospital management		√	√	Functioning specialist services and use
11.	Specialist services for disability specific conditions at secondary hospitals	Hospital management			√	Functioning specialist services and use
12.	Demonstrate in selected facilities and hospitals how disability inclusive services can be achieved	LMDMS/EDCD, GESI Section/MoHP	√	√	√	Learning products and exchange
Human resource capacity enhancement						
13.	Assessment of disability inclusion training needs of primary health staff	Provincial and local governments, NHTC, PHTC	√	√		Training needs assessments done
14.	Disability inclusion training of hospital staff including SSU staff	Hospital management, NHTC, PHTC		√	√	Hospital staff trained on disability inclusive health services
15.	Integration of disability inclusion in induction and in-service training	NHTC, PHTC	√			Disability-inclusion integrated into health training courses
16.	Disability inclusion training of primary health care staff	Local government, NHTC, PHTC	√	√	√	Primary health care staff trained on disability inclusion
17.	SSU staff trained to provide wellness function	Hospital management	√	√		SSU staff capacity
Information and evidence						

18.	Disability-disaggregated indicators included for selected indicators in HMIS	LCDMS/EDCD	√	√	√	Disability-disaggregated HMIS data
19.	Disability-disaggregated indicators included in hospital management information system	Hospital management		√	√	Information on hospital services provided to persons with disabilities
20.	Surveys and qualitative studies on health needs of persons with disabilities and use of services	LCDMS/EDCD		√	√	Evidence on health needs and use of services
Accountability						
21.	Integration of disability inclusion in hospital service charter	GESI Committees Hospital Management Committees, SSU	√			Disability inclusive service charter introduced
22.	Amendments to SSU guidelines include disability inclusion	Ministry of Health and Population	√			Procedures of SSUs revised
23.	Quality assurance of services provided to persons with disabilities	Hospital management		√	√	Quality standards met
24.	Social audit of disability inclusive health service system	Ministry of Health and Population Ministry of Social Development, Provincial government		√	√	Social audit conducted and report submitted
25.	Partnerships on disability inclusion with service providing organisations, DPOs and civil society organisations developed	MoHP, provincial and local governments		√	√	MoUs and meetings

4.8 Directives

As the Constitution of Nepal has entrusted the power to govern by exercising the authority to formulate and execute policies, laws, plan and programme and budget as per the respective needs, in this respect, the governments of the respective levels may regard this guideline as a directive for harmonizing the health service delivery system in line with disability inclusion.

4.9 Role of stakeholders

- a. Collaboration and partnerships with stakeholders at different levels shall be leveraged to achieve results. Effective collaboration with diverse organisations working in the field of preventive, promotive, curative and rehabilitative health services for persons with disability shall be encouraged and promoted.
- b. Disabled people's organisations, disability-related organisations, civil society organisations, community organisations, health users' groups, private sector organisations, etc. shall provide necessary support and advocate for the prioritization of disability inclusive health services and capacity development for full implementation of the guidelines.
- c. International development partners shall include disability inclusive health services as a priority in their support to the health sector. They are encouraged to support disability inclusive health programmes and related technical assistance.

4.10 Amendments and revisions to the guidelines

- a. The implementation of the federal governance structure as set out in the Constitution, policy, and law-making efforts are on-going. Structural reforms including legal and procedural arrangements at different levels are also in progress. Therefore, when there exists a stabilised set up of policy, legal and structural systems at all levels of government, it will become necessary to harmonise the guidelines with those set-ups and systems. The guidelines will be reviewed, and necessary revisions shall be made accordingly as and when necessary.
- b. The guidelines shall endure as a dynamic document and necessary review and revisions in the guidelines shall be carried out based on the feedback received and the recommendations made by the GESI Steering Committee of the Ministry. The Ministry shall ensure necessary coordination and harmonisation between the federal, provincial, and local levels along with the related ministries at the federal level by conveying the guidelines review report for necessary actions to be carried out by the ministries of the federal level, provinces and the local levels in an opportune time.

4.11 Provisions to remove difficulties

If any difficulty in the form of obstacles, problems, or ambiguities arises in connection with the execution of the guidelines, the Ministry may, upon the recommendation of the GESI Steering Committee address and resolve such obstacles or problems or ambiguities on a priority basis. The Ministry may interpret, add, amend, and make changes on the provisions of the guidelines as and when required in a participatory way.

Annex 1: Ministry of Health and Population List of Priority Assistive Devices

The Ministry of Health and Population, Priority Assistive Product List of Nepal (2018) sets out the following priority assistive devices:

1. Mobility

- Crutches
- Walking sticks and canes
- Walker
- Wheel chairs
- Lower limbs Orthoses
- Spinal Orthoses
- Lower limbs prostheses
- Upper limb prostheses
- Upper limb Orthoses
- Special devices for children with developmental delays
- Other products

2. Vision

- Spectacles
- Magnifying devices
- Tactile sticks
- Interactive products
- Writing products
- Other Products

3. Hearing

- Hearing Aids
- Communication products
- Signaling products
- Other Products
- Non-electronic augmentative and alternative communication
- Electronic augmentative and alternative communication

4. Cognition

- Personal Digital Assistance (such as battery powered computers that can be used anywhere – mobile phones such as smart phones and tablets)
- Memory Aids (such as pill organisers)
- Time devices
- Alarms

5. Environment

- Chairs
- Beds
- Wheelchairs accessories

Annex 2: Key Information for Mapping and Profiling of Persons with Disabilities

The following information will be collected by primary health care staff when mapping persons with disabilities in their catchment areas:

1. Name of the person with disabilities
2. Address (Municipality/Ward No./Area):
3. Date of birth:
4. Sex: Male/Female/Others
5. Disability Identity Card received: yes/no. If yes, insert ID number
6. If the person has a Disability Identity Card, type and severity of disability stated on the card:
7. If the person does not have a Disability Identity Card, functional limitations:
8. Living with the family: yes/no
9. Does the person support any family or non-family members: state whom
10. Is the person with disability supported by family or non-family members: state whom
11. Means of livelihood: Agriculture/business/employment/domestic work:
12. Health condition of the person with disabilities including co-morbidities:
13. Access to health service: yes/no. If not, list the main barriers
14. Medicines to be regularly used:
15. Therapy service used:
16. Assistive device used:
17. Any specific health condition requiring attention now: yes/no. If yes, did you refer

Annex 3: Gender Equality and Social Inclusion Institutional Structure

The GESI institutional structure is set out in the Ministry of Health and Population, Gender Equality and Social Inclusion Strategy, 2018.

