Nepal Health Sector Support Programme III

(NHSSP – III)

Report on Stocktaking the Health Policies of Nepal

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Report on Stocktaking the Health Policies of Nepal

Ministry of Health

Ramshahpath, Kathmandu, Nepal

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Executive summary

With the promulgation of the constitution in 2015, Nepal became a federal democratic republic nation. The federal, provincial, and local government have also been already formed and have been functioning as per the constitutional mandate. The organisational reform process is ongoing and further changes and adjustments are needed in various sectors to execute functions as per the constitutional provisions. In this way, the existing policies in the health sector have been reviewed to guide development of health related policies in the changed context. This report critically examines the health related existing policies and their relevancy in future in the federal context.

Altogether 22 health related policies were found to prevail in the health sector and were reviewed. A brief review of the policies, along with policy statements, has been included in the report for reference. Analysis of the policies was carried out from three perspectives:

1. Health system building blocks
2. Strategic directions of Nepal Health Sector Strategy (NHSS, 2015-2020)
3. Federal structure of the country (three levels of governance)

From the health system building blocks perspective, a majority of the policies have focused on governance followed by service delivery. The least addressed were infrastructure and equipment and pharmaceuticals and laboratory.

From the perspectives of NHSS strategic directions for universal health coverage, system reform, and quality dimensions were frequently covered in the policies. From the perspective of federalism, the policy statements were found mostly applicable for the federal level of government while many policy statements were equivocal to all three levels of government. The provincial level functions were less pronounced in the existing policies which is quite obvious in the context of previous unitary system of governance in the country.

On the basis of analysis and findings, the following recommendations have been made:

- Develop an umbrella health policy at the federal level in light of the functions of three levels of government covering each of the health system building blocks of health system. Such a policy document should also provide policy level guidance to federal, provincial and local government.
- As per the constitutional provision, federal, provincial and local governments have the authority to develop their own policy and laws not contradicting with federal and provincial policies and laws (for local government). In this context, developing health related policies in the future needs critical review of the functions assigned to the three tiers of government.
- Develop standards, Standard Operating Procedures (SOPs), and guidelines for the programmatic and thematic areas as relevant to guide the provincial and local level implementation in line with the assigned functions.
- Since the cabinet has the authority to approve policies, the federal policies should be approved by the cabinet which can also guide the provincial and local governments.
- The standard policy format of the cabinet should be followed when developing policies.
- As many services and topics are provisioned in the constitution and legal documents (example: basic health services, health insurance, safe motherhood, immunisation, etc.), these topics need careful consideration while developing policies.

- As per the provision of the constitution, a law governing the overall management of the health system should be developed to address that all the services spelled out as fundamental rights.
- Clear policy provisions must be made for the management of critical functions of the health service delivery e.g. blood transfusion services, procurement, and supply chain management in light of the functions of the three levels of government relating to policy and relevant strategies.
- The Constitution of Nepal 2015 indicates easy, convenient, and equal access to quality health services to all citizens. Therefore, realising this provision through policy and legislative document is essential.
- The fundamental aspects of the existing draft policies should be considered in developing the relevant policy, guidelines, and SOPs.
- Many policies acknowledge the need for partnership in the health sector but none of the policies provide clear directions for this. Therefore, future revision in the policy and strategies should provide policy directions for an effective partnership with private and non-government sector.
- As regards the health insurance and other mechanisms of social health protection, the federal government is responsible for policy, law, standards, and regulation while the provincial and local levels have a greater role to play in the execution of such policies as per the functional analysis and assignment (FAA). Furthermore, as the Health Insurance Act has been endorsed, the development of the regulations for health insurance should accordingly provide a legal base for reorganising the governance mechanism of the health insurance scheme.
- Many schemes of the social health protection are currently being implemented by the government which should be reviewed and aligned based on the evidence in future policy revision process.
- There is a critical need to define clear demarcation between basic health services and the health service package to be delivered through health insurance with proper interface amongst each other.
- The implementation aspects of the policy should be periodically reviewed and this can inform the implementation as well as policy revision in future.

List of Abbreviations

AHP	Ayurveda Health Policy
AMR	Anti- Microbial Policy
ANM	Auxiliary Nurse Midwife
AWPB	Annual Workplan and Budget
BHS	Basic Health Services
BTP	Blood Transfusion Policy
CAC	Comprehensive Abortion Care
DDA	Department of Drug Administration
DMP	Disability Management Policy
DoA	Department of Ayurveda
DoHS	Department of Health Services
DUDBC	Department of Urban Development and Building Construction
EHP	Eye Health Policy
EVM	Effective Vaccine Management
GESI	Gender Equality and Social Inclusion
GLP	Good Laboratory Practices
GoN	Government of Nepal
GMP	Good Manufacturing Practices
FAA	Functional Analysis and Assignment
HIP	Health Insurance Policy
HRP	Health Research Policy
HCT	Health Care Technology
HTP	Health Care Technology Policy
ICPD	International Conference on Population and Development
IDA	Iron Deficiency Anaemia
IDD	Iodine Deficiency Disorders
LCD	Leprosy Control Division
LMD	Logistics Management Division
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MHP	Mental Health Policy
MoFALD	Ministry of Federal Affairs and Local Development
MoHP	Ministry of Health
MP	Medicine Policy
NAP	National Abortion Policy
NATAC	National Antibiotics Therapeutics Advisory Committee
NGO	Non-Governmental Organisation
NHEICC	National Health Education, Information, and Communication Centre
NHP	National Health Policy
NHSS	Nepal Health Sector Strategy
NLM	National Medicine Laboratory
NLP	National Laboratory Policy
NNP	National Nutrition Policy
NHAP	National HIV/AIDS Policy
NHRP	National Health Research Policy
NVP	National Vaccination Policy
OHP	Oral Health Policy

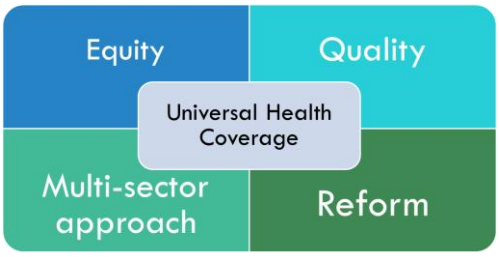
PAM	Physical Asset Management
PHCRD	Primary Health Care Revitalisation Division
PP	Population Policy
PPHS	Partnership Policy for Health Sector
PPICD	Policy, Planning, and International Cooperation Division
PPP	Population Perspective Plan
PWD	Person with disability
QAHS	Quality Assurance in Healthcare Services Policy
QBHS	Quality Basic Health Services
SAP	Safe Abortion Policy
SBA	Skilled Birth Attendants
SBAP	Skilled Birth Attendant Policy
SHN	School Health Nutrition
SMP	Safe Motherhood Policy
SOP	Standard Operating Procedures
STI	Sexually Transmitted Infections
TCAM	Traditional Complementary and Alternative Medicine
TTI	Transfusion Transmissible Infections
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UHP	Urban Health Policy
WHO	World Health Organization
WTO	World Trade Organisation

1. Introduction

1.1 Background

The National Health Policy (NHP) of 1991 was the first sectoral policy in the health sector of Nepal which primarily focused on the expansion of public health facilities in a rural setting. The policy called for the upgrading of the health status of the majority of the rural population by extending basic primary health services and making modern medical facilities available at the village level. Since then, a number of sub-sectoral policies, focusing on specific programme areas, have been developed. Furthermore, in 2014, a new NHP was developed which replaced the NHP of 1991. The goal of this new policy is to provide increased access to quality health services and ensure rights to health to all through equitable and accountable health service system.

The Nepal Health Sector Strategy 2016-21 (NHSS), as a continuation of the 'Nepal Health Sector Strategy: an Agenda for Reform', 2003; is the latest sectoral document in the health sector which also serves the operationalisation strategy of the NHP, 2014. The NHSS 2016-21 has adopted quality, equity, system reform, and multi-sectoral collaboration as the guiding principles to move towards universal health coverage.



In line with the spirit of the constitution, the country is currently executing federalism. The readjustment and reallocation of functions has been assigned across all three tiers of government, viz. local, provincial, and federal as per the constitutional mandate. Therefore, there is a need for the policies in health to be tailored or amended accordingly, to guide each level of government and to maximise federalism as an opportunity.

In the changed backdrop, it is necessary to look into the previous provisions stated in various policies when the country was in a unitary system. This activity is also an opportunity to engage with other relevant actors in updating policies, particularly keeping in mind some key areas like social determinants of health, management of health at local level, the referral system, and health worker availability in remote areas to ensure a smooth transition into the federal structure. This report summarises the essence of various health related policies of Nepal up to the year 2017.

1.2 Objectives

The overall objective of this study is to review the existing policies in the health sector to inform policy development and revisions in the federal context.

The specific objectives are as follows:

- To undertake a review of policies in the health sector
- To identify the appropriateness and gaps in the policies in relation to the federal context
- To inform policy development and revision in the future

2. Methodology and Limitations

2.1 Methodology

The methodology for the stocktaking of health sector policies was developed in consultation with the Policy, Planning, and International Cooperation Division (PPICD) of the Ministry of Health and Population (MoHP P). The overall approach and steps for the review of policy is depicted in the flow chart below (Figure 1).

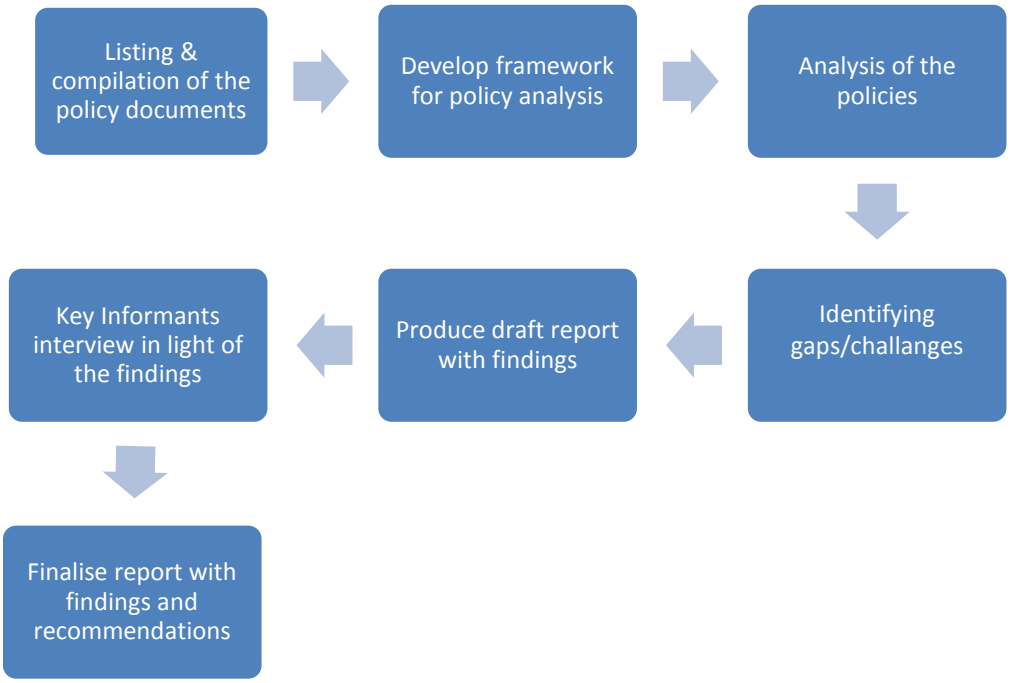


Figure 1: Approach for policy review

The listing of the policy documents was done through a search of various web-sites and searches in libraries. The website of the MoHP (www.mohp.gov.np) and the government's law commission (www.lawcomission.gov.np) are major sources of information. Moreover, websites of concerned departments and divisions were also consulted. Hard copies as well as soft copies were collected for the analysis and report writing. Only the documents which were titled as "policy" and related to the health sector were considered for further review and analysis which are listed below. Some of the policies were revised over years while most of the policies remain as they were originally developed.

Table 1. List of the existing policies in the health sector

SN	Name of Policy	Latest Edition (AD)
1	Disability Management Policy	2017
2	National Health Policy	2014
3	National Blood Transfusion Policy	2014
4	National Population Policy	2014
5	Urban Health Policy	2014
6	National Health Insurance Policy	2013
7	National Oral Health Policy	2013

SN	Name of Policy	Latest Edition (AD)
8	National Health Laboratory Policy	2013
9	National Health Communication Policy	2012
10	National Policy on HIV and STI	2010
11	National Health Research Policy	2010
12	Policy on Quality Assurance in Health Care Services	2007
13	National Skill Birth Attendant Policy	2006
14	Healthcare Technology Policy	2004
15	National Nutrition Policy	2004
16	National Safe Abortion Policy	2003
17	National Medicine Policy	2001
18	National Vaccination Policy on Safe Injection	2000
19	Policy on Multi-dose Vaccine Vial	2000
20	National Safe Motherhood Policy	1998
21	National Mental Health Policy	1996
22	National Ayurveda Health Policy	1996

All of the policy documents, with a few exceptions, have defined multiple policy statements mostly along with strategies to operationalise the policy statements. All the compiled policy documents were reviewed and policy statements were translated into English if they were in Nepali to facilitate further review and analysis. The goal, objectives, and policy statements as mentioned in the policy documents have been listed under the respective policy along with review of policy in the present context (Annex 1). The compilation of policy statements from the policies was done on the basis of their content. The policies which does not specifically incorporate policy statements (e.g., nutrition policy, health insurance policy), the specific objectives and/or strategies are included and reviewed with the assumptions that they can serve the purpose of policy statements.

The Framework for policy analysis was agreed upon looking into three aspects:

1. Building blocks of the health system
2. Strategic directions of NHSS
3. Functions assigned to three levels of government as per the Functional Analysis (based on the constitution 2015) and the Local Government Operation Act 2017

The categorisation of the policy statements under six building blocks of the health system was done based on the main thrust of the policy statement when a single statement contained more than one building block (e.g. human resource and service delivery). Statements with cross-cutting issues without clear linkage to any specific building block are loosely placed under governance, system reform, and equivocal columns depending on the theme of the statement. Policy statements pertaining to client services are essentially placed under service delivery. The basis for categorisation of the policy statements as per health systems building blocks is given Annex 2.

The second framework is guided by the strategic direction of NHSS to achieve the overarching goal of Universal Health Coverage, namely 1) Quality 2) Equity 3) System Reform and 4) Multi-sectoral Collaboration. Hence, the policy statements are categorised as per these four strategic directions. The basis for categorisation of policy statements as per strategic directions of NHSS is given Annex 3.

Similarly, the third framework is based on the functional analysis of health sector approved by the Government of Nepal (GoN) in light of the three levels of the governance. The policy statements relevant to a particular level of government or each of three level of governance and those of cross cutting nature are analysed under this framework. The basis for the categorisation of policy statements as per levels of governance is given Annex 4.

On the basis of these frameworks, the policy statements were mapped in accordance with the categories defined in tabular format. These tables were further analysed to find out the overall scope and coherence of the existing policies. The preliminary findings of the review were shared among the key stakeholders and discussed for their refinement in a workshop. It was supplemented by key informant interviews which led to the finalisation of the report along with recommendations.

2.3 Limitations

The methodology of the policy review and analysis has some limitations as mentioned below:

a. The review focused on policies developed by the MoHP and therefore policies relating to health that were developed by other ministries were not included in the analysis.
b. Similarly, the policy statements concerning the health sector defined in various periodic or annual plans of the government e.g. Periodic Development Plan (prepared by National Planning Commission) and Annual Work Plan and Budget (presented in annual budget speech) are not included in the analysis.
c. Some “strategies” and “guidelines” e.g. Free Health Services Guideline also provided policy directions in the health sector which are beyond the scope of this analysis and have not been included in this report.
d. All of the available policies until the end of 2017 were included in the analysis, however, policies existing only in draft form were not included in the analysis.
e. The policy statements were translated from Nepali to English for this analysis purpose and hence should be considered as “technical” and ‘’unofficial’’ translations.
f. The terminologies GoN and HMG/N are similar (keeping in view the change in the name over time). Similarly, the terminologies MoH and MoHP are also similar and reflect restructuring of government over time.
g. The implementation aspects of the policies were not analysed properly in this review. Categorisation of the policy statements under different components was done based on the defined set of qualifiers.

Given the aforementioned limitations, interpretations of category-wise analysis of the policy statements under various headings should be done cautiously.

3. Mapping and Analysis of the Policies

A stocktaking exercise was started by listing the health sector policy documents from different sources. An excel-based template was developed and an initial listing of the policies was carried out. Various sources were consulted before listing and compilation of the policies. The library at the MoH was the main source of the policies.

Although different health sector documents were initially listed, only the documents titled as 'policy' were considered for the review purpose. A separate list of policy documents that exist in 'draft form' are given below, however, these are not included in the stocktaking exercise. A total of 22 policies have been found relating to the health sector and developed by the MoH and its entities.

The table below lists the health related policies, the latest policy being the first listed (in reverse chronological order)

SN	Name of Policy	Latest Edition (AD)	Previous Editions
1	Disability Prevention Policy	2017	
2	National Health Policy	2014	1991
3	National Blood Transfusion Policy	2014	1993, 2006
4	National Population Policy	2014	
5	Urban Health Policy	2014	2010
6	National Health Insurance Policy	2013	
7	National Oral Health Policy	2013	2004
8	National Health Laboratory Policy	2013	
9	National Health Communication Policy	2012	
10	National Policy on HIV and STI	2010	1995
11	National Health Research Policy	2010	2003
12	Policy on Quality Assurance in Health Care Services	2007	
13	Healthcare Technology Policy	2004	
14	National Skill Birth Attendant Policy	2006	
15	National Nutrition Policy	2004	
16	National Safe Abortion Policy	2003	
17	National Medicine Policy	2001	1995
18	Multi-dose Vial policy	2000	
19	Policy on Multi-dose Vaccine Vials	2000	
20	National Safe Motherhood Policy	1998	
21	National Mental Health Policy	1996	
22	National Ayurveda Health Policy	1996	

A total of 22 health related policies were developed by the MoHP in the last 27 years. The first being the NHP of 1991 and the latest being the Disability Management policy of 2017. Of the total 22 policies, eight policies (NHP, UHP, PP, MP, HIP, QAHCS, and PPHS) are cross- cutting in nature and are invasive, whereas the rest target specific health services.

Several policies are currently under development and not endorsed yet. A list of these policies is given below:

SN	Title	Year (AD)	Remarks
1	Partnership Policy in Health (PPH)	2017	New
2	National Eye Health Policy (EHP)	2017	New
3	Anti-microbial Resistance Policy (AMR)	2017	New
4	National Health Policy	2017	Revision
5	National Ayurved and Complementary Medicine Policy	2017	Revision
6	National Mental Health policy	2017	Revision
7	National Medicine Policy	2017	Revision
8	National Policy on Nursing and Midwifery	2017	New

Besides these policies, various strategies have also been produced by the MoH, which in fact are broader and cross-cutting by contents. A list of them is given below:

SN	Title	Year (AD)	Remarks
1.	Nepal Health Sector Strategy	2016	2016-21
2.	Communication Strategy on Safer Motherhood	2012	2012- 16
3.	Communication Strategy on Adolescent Sexual and Reproductive Health Strategy	2012	2012- 16
4.	Neonatal Health Strategy	2004	
5.	Nepal Health Sector Strategy: Agenda for Reform	2004	
6.	National Adolescent Health and Development Strategy	2000	
7.	National Neonatal Health Strategy	2004	
8.	National Safe Motherhood Strategy	1998	
	National Anti-Tobacco Communication Campaign Strategy		
9.	National Adolescent health and development strategy	2000	
10.	National FCHV strategy		
11.	Health Sector GESI strategy	2009	
12.	National Strategy on Health Sector Information System	2007	
13.	National Anaemia Control Strategy	2008	
14.	National Training Strategy	1997	
15.	National RH research strategy	2000	
16.	National Strategy for Reaching the Unreached	2016	
17.	Strategy for Infants and Young Child Feeding	2014	
18.	National School Health and Nutrition Strategy	2006	
19.	National strategy on HIV Drug Resistant Monitoring & Surveillance in Nepal 2014-2020	2014	
20.	National HIV Strategy (Plan) 2016-21	2016	
21.	Nepal Malaria Strategic Plan 2014-2025	2014	

22.	National Communication Strategy On MNCH	2012	
23.	National Reproductive Health Strategy	1998	
24.	Health Sector Strategy for Addressing Maternal Under-Nutrition	2013	2013-17

From the above list, it can be inferred that there is a plethora of health related policies and strategies.

4.1 Framework for mapping and analysis of policies

Identifying an appropriate conceptual framework to do a contextual policy stock take is challenging. A number of widely used frameworks and theories of the public policy process are found in the literature (Gill Walt et. all, 2008). While helpful, these models tend to treat the policy process as a 'black box' providing little insight into how and why certain policies are made, or at times, not made (Brent Moloughney, 2012).

In the preliminary scoping of the literature, a limited number of policy frameworks were repeatedly encountered. However, most of these frameworks and theories tend to focus on policy process, rather than suggesting an appropriate policy stocktaking framework. It is found that some researchers have applied stages of policy evaluation in the health sector (Scott Miller, 2015) and some have suggested an economic evaluation of the policies (Phaedra S. Cosro, 2014).

As policies are broad and cross cutting in nature, compiling them into a certain framework is challenging and at times not justifiable, as the contexts vary. With an aim to link the existing policies with heath systems components and sectoral outcomes, a two-way table was developed as a framework for the mapping and analysis of the existing policy contents.

The framework was developed in line with the NHSS outcome areas, health system components, and three levels of governance. All the policy provisions defined in different policy documents were mapped as per the analytical framework as described in the methodology. In the instances, when the existing policy documents did not have specific policy provisions, defined policy objectives or strategies were used as a reference for the stock taking exercise. All the policy provisions defined in different health sector policies are presented below under six thematic areas which provided the basis to identify gaps and issues in the existing policy documents.

The listed policies were further analysed under three frameworks agreed with the PPICD. The first framework is based on the health system building blocks[1] of the WHO. The critical areas such as physical infrastructure and pharmaceuticals were separated for the sake of the stock taking as they are differently managed in the Nepalese health system. Recently, an integrated health infrastructure development project has been approved by the GoN while the main responsibility of managing the construction works is of Department of Urban Development and Building Construction (DUDBC). On the other side, pharmaceutical management and laboratory management is one of the critical functions internally managed by the MoHP that has major implication in the current federal context as the roles of different levels of governments in the procurement and supply chain has yet to be

[1] 1) Governance 2) Physical infrastructure and equipment 3) Health Service management 4) Pharmaceutical and laboratory management 5) Health Financing 6) Human resources for health and 7) Information and research

clarified. The second framework is based on NHSS strategic directions and the third one is based on the functional analysis of the three levels of government.

4.2 Mapping policies as per health system building blocks

The consolidated analysis of the policy statements of each policy under each health system building block is given in **Table 2.** The numbers in the tables are the number of policy statements pertaining to each building block.

Table 2: Analysis of various policies on the basis of the building blocks of the health system

SN	Policies	Governance	Infrastructure & equipment	Service Delivery	Pharma & Lab	HRH	HF	Information & research	Total
1.	Disability Management Policy	3	2	7	-	2	-	4	18
2.	National Health Policy (NHP)	7	-	2	1	1	1	2	14
3.	National Blood Transfusion Policy (BTP)	3	1	2	1	-	1	2	10
4.	National Population Policy (PP)	7	1	-	-	-	-	1	9
5.	Urban Health Policy (UHP)	4		1			1		6
6.	National Health Insurance Policy (HIP)	4	-	6	-		6	-	16
7.	National Oral Health Policy (OHP)	3	-	2	-	-	-	1	6
8.	National Health Laboratory Policy (LP)	5	1	-	2	1	1	2	12
9.	National Health Communication Policy	4	1	2	-	1	1	11	20
10.	National Policy on HIV and STI (NHP)	22	-	2	-	-	-	2	26
11.	National Health Research Policy (HRP)	1	-	-	-		-		1
12.	Policy on Quality Assurance in Health Care Services (QAHCS)	3	-	-	-	-	-	-	3
13.	National Skilled Birth Attendants Policy (SBA)	4	-	1	-	3	-	-	8
14.	Health Care Technology Policy (HTP)	4	2	1	-	-	2	2	11
15.	National Nutrition Policy (NNP)	7		54				1	62
16.	National Safe Abortion Policy (NSAP)	7		8					15
17.	National Medicine Policy (MP)	26	3	1	5	5		4	44

18.	National Vaccination Policy (NVP)	-	-	3	-	-	-	-	3
19.	Policy on Multi-dose vaccine vial			1					1
20.	National Safe Motherhood Policy (SMP)	2		1					3
21.	National Mental Health Policy (MHP)	2	-	1	-	1	-	-	4
22.	National Ayurveda Health Policy (AHP)	10	7		2	9	1	3	32
	Total	**128**	**18**	**95**	**11**	**23**	**14**	**35**	**324**

This table shows the pattern of statements in the WHO's building blocks of health system. The majority of the policy statements were found to be around governance. The qualifiers of governance were: legal arrangement, rights, governance, system, regulation, and management. Furthermore, collaboration, coordination, institutional structures, and quality are also included in governance. The second frequently addressed building block was service delivery. This was followed by human resources, qualifiers being training, job, and academy. The minimum number of policy statements were found under the categories of health financing, pharmaceuticals, and laboratories and infrastructure.

4.3 Mapping the policies as per the strategic directions of NHSS

The second framework is guided by the strategic directions of NHSS to achieve the overarching goal of Universal Health Coverage namely 1) Quality 2) Equity 3) System Reform and 4) Multi-sectoral Collaboration. The consolidated mapping of the categories analysis as per NHSS strategic directions are given in the **Table 3.**

Table 3: Analysis of the policies on the basis of the NHSS direction

SN	Policies	Quality	Equity	System Reform	Multi-sectoral	Total
1.	Disability Management Policy	3	5	6	2	18
2.	National Health Policy (NHP)	5	3	4	2	14
3.	National Blood Transfusion Policy (BTP)	6	-	3	1	10
4.	National Population Policy (PP)	1	5	2	1	9
5.	Urban Health Policy (UHP)	2	1	3		6
6.	National Health Insurance Policy (HIP)	1	6	7	2	16
7.	National Oral Health Policy (OHP)	1	1	3	1	6
8.	National Health Laboratory Policy (LP)	5	1	6		12

9.	National Health Communication Policy	5	4	9	2	20
10.	National Policy on HIV and STI (NHP)	5	5	10	6	26
11.	National Health Research Policy (HRP)			1		1
12.	Policy on Quality Assurance in Health Care Services (QAHCS)	1		1	1	3
13.	National Skilled Birth Attendants Policy (SBA)	1	1	3	3	8
14.	Health Care Technology Policy (HTP)	1	2	7	1	11
15.	National Nutrition Policy (NNP)	17	8	37	-	62
16.	National Safe Abortion Policy (NSAP)	7	2	6		15
17.	National Medicine Policy (MP)	22		18	4	44
18.	National Vaccination Policy (NVP)	3	-	-	-	3
19.	Policy on Multi-dose vaccine vial	1				1
20.	National Safe Motherhood Policy (SMP)	1	-	2	-	3
21.	National Mental Health Policy (MHP)	1	1	1	1	4
22.	National Ayurveda Health Policy (AHP)	10		19	3	42
	Total	**99**	**45**	**150**	**30**	**324**

This table categorises various policy statements on the basis of NHSS' strategic directions for universal health coverage. Most of the policy statements are found to be in the system reform category followed by quality of care. Equity was least spelt out in the policy statements.

4.4 Mapping the policies as per the three levels of government

The third framework for the analysis of policy statements was to review existing policy provision vis-à-vis functional analysis in light of the three levels of the government. Table 4 presents the number of policy statements relevant to three level of governments and those are of cross cutting nature (termed equivocal).

Table 4: Analysis of policy statements on the basis of delegation of authority by level of government

SN	Policies	Federal	Provincial	Local	Equivocal	Total
1	Disability Management Policy	3	--	-	15	18
2	National Health Policy (NHP)	5	1	6	2	14
3	National Blood Transfusion Policy (BTP)	3	-	3	4	10
4	National Population Policy (PP)	-	1	2	6	9

5	Urban Health Policy (UHP)			6		6
6	National Health Insurance Policy (HIP)	1		2	13	16
7	National Oral Health Policy (OHP)	2		2	2	6
8	National Health Laboratory Policy (LP)	2		3	7	12
9	National Health Communication Policy	3		2	15	20
10	National Policy on HIV and STI (NHP)	8	1	10	7	26
11	National Health Research Policy (HRP)				1	1
12	Policy on Quality Assurance in Health Care Services (QAHCS)	1			2	3
13	National Skilled Birth Attendants Policy (SBA)	1		2	5	8
14	Health Care Technology Policy (HTP)	2	-	4	5	11
15	National Nutrition Policy (NNP)	2		4	56	62
16	National Safe Abortion Policy (NSAP)			1	14	15
17	National Medicine Policy (MP)	6	1		37	44
18	National Vaccination Policy (NVP)	-	-	3	-	3
19	Policy on Multi-dose vaccine vial				1	1
20	National Safe Motherhood Policy (SMP)	2	-	1	-	3
21	National Mental Health Policy (MHP)	2	-	1	1	4
22	National Ayurveda Health Policy (AHP)	7	2		23	32
	Total	**50**	**6**	**52**	**216**	**324**

From the angle of implication of the policy statement, most of the policy statements fit into the federal or equivocal category. As provinces are the new structure in the governance, we did not expect to cover the provincial government in the policies which are approved well before promulgation of the Constitution. However, a number of policies have incorporated the content relevant for the local level.

4. Findings and Recommendations

5.1 Findings and discussion

From the analysis, it was revealed that categorisation of policy statements provides a weighted picture of the policies. This means various "policies" fit more appropriately into the following:

1. Laws and Regulations
2. Policy as such
3. Standard
4. SOPs

Legally mandated statements are more appropriately dealt with laws and regulation. For example, the Health Insurance Policy now is addressed by the Health Insurance Act, and the Safe Abortion Policy by safe abortion procedures. The relevancy of these policies has been already addressed.

Some of the policies focused on a particular service or programme area which hence appears to be sub-sectoral in nature, such as medicine policy or blood transfusion policy. Such sub-sectoral areas could be better addressed by developing standards which is a mandate for the federal government as per the FAA.

Some of the "policies" in current use fit more appropriately into SOPs such as the health laboratory policy, mental health policy, anti-microbial resistance policy, and vaccination related policies. All of the prevailing policies in the health sector were developed in the unitary system of government, federal (or central) and "equivocal" categories were more pronounced than local or provincial.

Table 5 below summarises the appropriateness of the policies in various categories such as "General Policy as such", "sub-sectoral policy", and "Standards or SOP". This categorisation looks at cross cutting nature of policy statements, but is arbitrary.

Table 5: Appropriateness of the policy in various categories

Policies	Appropriate as "policy"	Appropriate as Sub-sectoral policy	Appropriate as standard or SOP	Remarks
1. Disability Prevention Policy		Y		
2. National Health Policy (NHP)	Y			
3. National Blood Transfusion Policy (NBTP)		Y		
4. Urban Health Policy (UHP)		Y		
5. National Population Policy (PP)	Y			
6. National Health Insurance Policy (HIP)			Y	Law enacted
7. National Oral Health Policy (OHP)			Y	

Policies	Appropriate as "policy"	Appropriate as Sub-sectoral policy	Appropriate as standard or SOP	Remarks
8. National Health Laboratory Policy (LP)		Y		
9. National Health Communication Policy		Y		
10. National Policy on HIV and STI (NHP)		Y		
11. National Health Research Policy (HRP)		Y		
12. National Medicine Policy (MP)		Y		
13. Policy on Quality Assurance in Health Care Services (QAHCS)			Y	
14. Health Care Technology Policy (HTP)			Y	
15. National Skilled Birth Attendants Policy (SBA)			Y	
16. National Nutritional Policy (NNP)		Y		
17. National Safe Abortion Policy (NSAP)			Y	Law enacted
18. National Vaccination Policy (NVP)			Y	Law enacted
19. Policy on Multi-dose vaccine vial			Y	
20. National Safe Motherhood Policy (SMP)			Y	
21. National Mental Health Policy		Y		
22. National Ayurved Health Policy		Y		

The inference is that the policy development needs to be based on the building block of the health system and the four strategic directions of the NHSS framework to address the UHC and the SDG and definitely as per the allocation of functions to different levels of government. The following are the major gaps and challenges found based on the review:

- All of the existing policies were developed under the unitary system of governance. Their relevance in the federal context was found to be minimal to govern as "policy directives" to different levels of governance.
- There was a lack in the uniformity in the policy documents as per the practiced template of the cabinet.
- Some policies do not have "policy statements" per-se e.g. the Nutrition Policy and Health Insurance Policy.
- The majority of the policies did not have the goals, targets, and defined time frames.
- In some policies, the policy statements were contradictory to each other. e.g. in the Oral Health Policy, the policy statement said that no additional resources is required to implement the policy while in the same document another statement under financial resources said that GoN is required to allocate additional resources to implement the policy.
- It was difficult to locate policy documents as, often in the official websites, the draft policies were uploaded instead of final version.
- Most of the "policies" can be considered as "standards" or SOPs.
- Some strategies and guidelines were as powerful as policy e.g. Free Health Care Guidelines.
- Blood transfusion services: As per NHP it is a centralised function. However, as per FAA it is the mandate of the local government. Therefore, clear gap in the linkage in the blood transfusion service and its management exists.
- The International Commitments made by the GoN is not sufficiently reflected in the concerned policy documents e.g. The Ayurveda Health Policy does not cover the WTO commitments.
- There were some inconsistencies regarding the approving authority for the policies. e.g. national drug policy 1995 was approved by the cabinet while the revision of the same policy was approved by the Ministerial level.
- Only some policies were followed by the development of corresponding Acts e.g. National Health Insurance, while Safe abortion Act and the national drugs Act came before the policy.
- Some policies were developed in silos and seemed to be disconnected to the bigger health system building blocks e.g. The SBA Policy and it linkage with the bigger HRH.
- In most policies, the problems and challenges enunciated in developing the policies were not addressed by the policy statements.
- Except for the review of National Health Policy of 1991, it was found that none of the health sector policies were reviewed to date.
- Some policies did not address the equity aspects e.g. National health Communication policy, National Ayurveda Health Policy.
- Some policies were not sufficiently informed by evidence.
- The policies listed above, are not followed by their implementation plans. So the status of policies in the absence of their time bound implementation framework supported by financial resource, becomes poor.
- Based on the discussion with concerned stakeholders, it can be concluded that 'articulating a reasonable policy is one thing; actually implementing it successfully is another'. As Matt Andrews, Lant Pritchett, and Michael Woolcock (2016) argue in a different context and reveal that 'there is rarely a follow-up discussion on who, exactly, will implement these policy "implications," or whether the administrative systems charged with implementing any policy can actually do so, or whether a given policy success or failure actually stems less from the quality of its "design" and more from the willingness and ability of the prevailing

apparatus to implement'. Although the details of implementation status of the policies could not be analysed, these statements very much stand realistic while analysing the health related policies in Nepalese context.

- Most of the policies have not addressed the financing aspect for the implementation of the policy.

5.2 Recommendations

On the basis of review of the existing policies and considering current federal context following recommendations are suggested:

- Develop umbrella health policy at federal level in light of the functions of three levels of government covering each of the health system building blocks of health system. Such federal policy document should also provide policy level guidance to federal, provincial and local government.
- Develop Standards, SOPs and guidelines for the programmatic and thematic areas as relevant to guide the provincial and local level implementation in line with the assignment functions.
- As per the constitutional provision, provincial and local governments have the authority to develop their own policy and laws not contradicting with federal and provincial policies and laws (for local government). In this context, developing health related policies in future needs critical review of the functions assigned to three tiers of government.
    a. As per the FAA role of federal ministry of health is to define the scope of Basic Health Service and develop standards. Therefore, the new health policy should include these aspects.
    b. Collaboration and cross cutting issues with other government entity are important aspects to consider.
    c. The revision of health policies should consider reflecting the international commitments e.g. WTO, International Health Regulation and so on. Therefore, as this has been identified as one of the function of federal MoHP, the federal policy must take this aspect into consideration.
    d. The FAA has clearly indicated developing health tourism and related policies, laws and standards as the function of the federal government. Therefore, revision of health policy should include these aspects.
    e. Referral services will change in the current content. So the revision of policy should consider inter-Palika and interprovincial referral aspects as well.
    f. Emergency health services is one of the critical component provisioned in the constitution while each of the three levels of government are assigned the role of emergency services delivery. Therefore, revision of policies should be considered to account for this.
    g. Policy provisions require revision in light of the drug management functions assigned to different levels of government. As per the FAA, the federal government has the mandate to develop and regulate quality standards while provinces have roles primarily on pharmacovigilance, the rational use of drugs, and procurement and the local level has the mandate of procurement and supply chain management.
    h. In the current context, financing for the secondary and tertiary services is expected to be through health insurance while the local level plays major role in delivering basic health services, the financing of which will be done by the federal government. Provinces have mixed roles for the delivery of health services as well as

regulation. The revision of health sector policies must consider these changes in health financing.

- System reform needs major attention in the federal context keeping in view three tiers of government. As mandated by the constitution, the federal ministry could focus on developing standards and SOPs.
- Since the Cabinet has the authority to approve policies, the federal policies should be approved by the Cabinet which can also guide to the provincial and local governments.
- The standard policy format of the Cabinet should be followed when developing the policies.
- As many services and topics are provisioned in the constitution and legal documents (example: basic health services, health insurance, safe motherhood, immunisation, etc.), these topics need careful consideration while developing policy.
- As per the provision of the constitution, a law governing the overall management of the health system should be developed to address that all the services spelled out as fundamental rights.
- Clear policy provisions for the management of critical functions of the health service delivery e.g. blood transfusion services, procurement and supply chain management need to be addressed in light of the functions of three levels of government in terms of policy and relevant strategies.
- The Constitution of Nepal 2015 indicates easy, convenient, and equal access to quality health services to all citizens. Therefore, realising this provision through policy and legislative document is essential.
- The fundamental aspects of the existing draft policies should be considered in developing the relevant policy, guidelines and SOPs.
- Many policies acknowledge the need of the partnership in health sector but none of the policies provide clear directions. Therefore future revision in the policy and strategies should provide policy directions for an effective partnership with private and non-government sector.
- As regards the health insurance and other mechanism of social health protection, the federal government is responsible for policy, law, standards, and regulations while provincial and local levels have a greater role to play in the execution of such policies as per the FAA. Furthermore, as the Health Insurance Act has been endorsed, the development of the regulations for health insurance should accordingly provide legal base for reorganising the governance mechanism of the health insurance scheme.
- Many schemes of the social health protection currently being implemented by the government which should be reviewed and aligned based on the evidence in future policy revision process.
- There is a critical need to define a clear demarcation between basic health services and the health service package to be delivered through health insurance with proper interface amongst each other.
- The implementation aspects of the policy should be periodically reviewed which can inform the implementation as well as policy revision in future.

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6. Annexes

Annex 1: Excerpt and review of individual policies

This section presents the goal, objectives, and policy statements as defined in the policy documents. This is followed by a brief review of the policy statements for the each of the health sector related policy documents.

A1.1 Disability Management Policy, 2017

This policy was recently developed in 2017 (2073 BS) to address the issue of disability. The full name of the document is Disability Management (Prevention, Treatment, and Rehabilitation) Policy, Strategy and ten years Action Plan (2073 – 2082). The population census of 2011 showed that 1.94% of the total population comprised persons with disabilities (PWD). It is stated that PWD face social discrimination, lower access to basic services and support, a lack of disability friendly infrastructures and services, hindrances to enjoying human rights, discriminatory laws and practices, and a lack of participation in decision making processes. In 2006, December 13, the United Nations ratified the "Convention on the Rights of PWDs" realising the need of international law for PWDs. The Parliament of Nepal also passed this treaty on December 27, 2009. Nepal also has the "Disability Protection and Welfare Act 2039". With this background, the policy was developed to address various disability related issues.

Goal:

To help PWD to fully enjoy their human rights secured by the constitution of the Nepal and including United Nations' Convention on the Rights of Persons with Disabilities (UNCRPD)and other documents related to rights of PWDs and providing rehabilitation and other health services and opportunities as equal as other citizens.

Purpose of the policy:

The policy has the following purposes:

- To increase access to the promotional health services, reproductive health programmes and health related information and communication (including promotional, early detection/identification of disease/status, rehabilitation, and other health services) for the disabled population
- To conduct disability prevention and reduction related health programmes effectively with better coordination
- To make access for PWDs as equal as other citizens for basic health services and to provide needs based specialised health services and rehabilitation
- To deepen the early identification of disability with programmes set up at the community level
- To provide support for NGOs working in disability management by evaluating their performance

The purpose is followed by 12 targets.

Number of Policy Statements: 18

Statements

Statements
1) Disability prevention, rehabilitation, and management will be done under integrated health services with high prioritising. 2) Disability prevention, rehabilitation, and management programmes health related plans, Monitoring and Evaluation (M&E) will be done by the Department of Health Services (DoHS), and Leprosy Control Division (LCD) under the MoHP . 3) Organising the required human resources for disability prevention, rehabilitation, and management programmes 4) Enhancement and management of the referral system 5) Reports and records to be done under the health management information system (HMIS) in an integrated way 6) Increasing and enhancing the level and developing the capability of the present government health centres and institutions to provide basic and specialised health services to the PWD 7) Operating and managing the available specialised health and rehabilitation services provided by the non-governmental sector in a coordinated way 8) Increasing disability related information by making health information and the information dissemination system and mediums disability friendly 9) Implementing child health and nutrition related government programmes targeting children with disability 10) Implementing programmes targeting the prevention of disability by birth, disability due to injuries, mental disability, and disability caused by communicable and non-communicable diseases 11) Developing human resources capable of early identification, required counselling, and referral services at the village level through the local health centres 12) Developing and modification of the physical infrastructures of health institutions and health centres to make disability friendly as stated by the GoN building code 13) Undertaking studies to know the problems and challenges related to the reproductive health of women with disability and carry out special programmes 14) Identifying lifelong medicines to be consumed by the PWD due to their physical or mental condition and providing them free of cost respectively 15) The negative implications that could be seen in future due to physical and mental health of PWD will be promptly recognised and minimised 16) Up to date promotion of, studies/research and development of medicines, equipment and new technologies 17) Encouraging and creating a favourable environment for the private sector to provide services to the PWD 18) Various techniques will be applied to protect and prevent disability

Review

- This policy encompasses the policy, strategies, and action plan for ten years. From a health system building blocks perspective, the policy focuses more on health services and information/research.
- From the perspectives of NHSS strategic directions, it addresses the health system reform and equity related aspects.
- Although the policy was formulated after the promulgation of the constitution, from the perspectives of assignment of function across three levels of government, the majority of

the statements are equivocal and there is no specific function for local and provincial governments.

- The policy has been approved at the Ministry level, not by the Cabinet of Ministers. Similarly, the usual template of policy formulation is not followed strictly.
- The best part of the policy is that it has been accompanied by the action plan with the activities, monitoring indicators, time frame, and the responsible agencies to execute the activities. However, the action plan has not properly addressed the financing part of its implementation.
- The LCD of the DoHS has been given the responsibility to address rehabilitation
- Collaboration with non-government organisations is ongoing

A1.2 National Health Policy, 2014

The NHP was developed in 2014 replacing the previous NHP of 1991. While the policy was approved, the present Constitution was being drafted, and the country was governed on the basis of the Interim Constitution. The policy mentions that the previous NHP was insufficient to ensure citizen's rights to quality health care. It has adopted the following guiding principles for the development of the policy:

- Fundamental right of citizens for obtaining quality health care
- Right to information related to the health services
- Health services accessible to poor, marginalised, and vulnerable communities based on equality and justice
- People's participation
- Participation of the private sector
- Mobilisation of resources
- Regulation of health services
- Accountability of health services

Goal: To ensure health for all citizens as a fundamental human right by increasing access to quality health services through a provision of a just and accountable health system.

Objectives

- To make available free basic health services that existed a citizen's fundamental right
- To establish an effective and accountable health system with required medicines, equipment, technologies, and qualified health professional for easy access to acquire quality health services by each citizen
- To promote people's participation in extending health services- for this, promote ownership of the private and cooperative sector by augmenting and managing their involvement

Number of policy statements: 14

Statements
1) To make available in an effective manner the quality health services, established as a fundamental right, ensuring easy access within the reach of all citizens (UHC) and provision of basic health services free of charge
2) To plan produce, acquire, develop, and utilise necessary human resources to make health

Statements
services affordable and effective 3) To develop the Ayurvedic medicine system through the systematic management and utilisation of available herbs in the country as well as safeguarding and systematic development of other existing complementary medicine systems 4) To ensure simple and effective supply and utilisation of quality medicine and medical products and enhancing the capacity of domestic production so that country gradually becomes self-dependent 5) To improve the quality of health research in line with international standards and establish effective mechanisms to translate these into policy making, planning, and medicine systems 6) To promote public health by giving high priority to health education, information, and communication programmes to protect people's fundamental right to health information 7) To reduce the prevalence of malnutrition through the promotion and use of quality healthy foods 8) To ensure availability of quality health services through competent and accountable mechanisms and systems for coordination, monitoring, and regulation 9) To ensure professional and quality service standards by making health related professional councils capable, professional, and accountable 10) To mainstream health in every policy of state by reinforcing collaboration with health related various stakeholders 11) To ensure the right of citizens to live in a healthy environment through effective control of environmental pollution for protection and promotion of health 12) To maintain good governance in the health sector through necessary policy, structure, and management for delivery of quality health services 13) To promote public and private sectors partnership for systematic and quality development of the health sector. 14) To increase the investment in the health sector by state to ensure quality and accessible health services and to provide financial security to citizens for medical cost and as well as effectively utilise and manage financial resources obtained from private and non- government sector.

Review

- The NHP was developed for the first time in 1991 and the current policy came after 23 years following the review of the original policy that it replaced.
- The NHP mainly focuses on the fundamental right to health, universal health coverage, and the free provision of basic health services.
- The policy has the provision of availability of various cadres of health workers, quality medicines, and equipment purchased through rigorous selection process and adhering to good manufacturing practices (GMP) standards.
- Many of the policy statements are more like the objectives than being policy as such. However, each policy statement has multiple strategies which address operational approaches for the respective policy statement.
- Many issues pertaining to the social determinants of health are not included in the policy such as, occupation and migration health.
- Some of the critical components of the health sector management such as volunteerism in health, management of autonomous entities, and regulation of private sector, are less pronounced.

- Many policy statements are equivocal in nature and are not well aligned with the functions of the federal structure considering various constitutional provision and legal mandates.
- The control of communicable and non-communicable diseases, emergency health care, rehabilitative and palliative health service, infrastructure development, climate change, and zoonotic disease control are some of the major areas which did not find a place in the policy.
- In the changed federal context, the policy needs to be updated in accordance with the functions of the three levels of government. In this regard, two high level committees along with technical committees were recently formed to revise the policy in the federal context and they submitted the draft policy document to the MoH. The draft submitted by the later committee was also submitted to the cabinet of Ministers which however has not been endorsed.

A1.3 National Blood Transfusion Policy, 2014

The latest version of the policy is the third of its kind. The policy on blood transfusion was originally developed in 1993 (2055 BS) which was later updated in 2006 (2063 BS). Both the first and second version of the policies were named as "National Blood Policy" while the latest revision was produced in 2071 BS. With the approval of this policy, the national blood policy of 2006 has been repealed.

The rationale behind the revision of the policy was to promote the use of international technology and standards in all centres throughout the country. The scope of the policy is limited to the services of blood transfusion, which was mentioned in the NHP, 1991.

Goal

To provide quality, and safe blood and blood components to all people living in Nepal with easily accessible and as needed.

Objectives

To establish an organisational, financial, and legal base to ensure the supply of a safe and adequate supply of blood through one hundred percent voluntary and non-remunerable blood donation.

Number of Policy Statements: 11

Statements
1) To establish a national blood programme with legal framework and to establish the national blood transfusion service with adequate infrastructure and coordination
2) To establish a blood transfusion service through the national blood programme with a legal framework, adequate infrastructure, and coordination
3) To develop and enhance the capacity of human resources under the national blood programme
4) To integrate the national blood programme into the health services system
5) To ensure the sustainability of the national blood programme
6) To encourage regular blood donors and collect blood through a voluntary and non-remunerated modality at a national scale
7) To improve the safety and use of blood and its components by following good clinical practices and good laboratory practices (GLP) for blood grouping and transfusion transmissible infections (TTI) and GMP for processing of blood components
8) To promote appropriate and safe use of blood in medical procedures

9) To establish a quality management system
10) To develop a national management information system
11) To develop cooperation and collaboration with national and international partners

These policy statements are followed by a number of strategies and working policies. However, in the strategy part of the policy document, these policy statements are taken as objectives.

Review

- There have been three revisions of the policy: the first policy- named "National Blood Policy" was developed in 1993. It was further updated and revised in 2005. The latest was endorsed in 2014.
- Most of the building blocks are covered.
- The policy is explicit on the quality aspects from the perspective of NHSS strategic directions.
- Since the policy was approved prior to the Constitution, its relevancy with regards to the FAA needs to be reviewed.
- It promotes voluntary and non-remunerated blood donation and it has provision for service expansion in remote districts.
- Although one of the rationales of the policy is to develop/use the international technology and standards in the field of blood transfusion in all centres throughout the country, the policy statements do not portray this accordingly.
- As a part of the policy format, a number of problems and challenges are mentioned in the policy document, however the policy statements do not address these problems accordingly.
- Although, the policy mentions that a common mechanism needs to be developed for the government and blood transfusion service providers, it is yet to be practiced fully. However, since the policy is relatively new, it is early to conclude about its implementation status.
- The policy does not cover the hemovigilence and legal aspects related to blood transfusions.
- This policy is a sub-sectoral policy exclusively dealing with blood transfusion services.

A1.4 National Population Policy, 2014

This policy mulls over population and its linkage with other developmental areas as articulated in the post International Conference on Population and Development (ICPD) framework. It reveals Nepal's dedication that population related issues must not be isolated from other development agendas. To address Nepal's commitment to ICPD, the Population Perspective Plan (PPP) (2010-2031) was developed. This policy mainly aims to reduce fertility rate to replacement level and alleviate poverty. The basis of the National Population Policy is the PPP.

Objectives of the Policy

- To establish population management as an indivisible part of the overall development through maintaining coherence between population and development
- To develop services like sexual and reproductive health and family planning as rights based programmes
- To ensure the quality of health services for healthy living
- To manage external and internal migration and urbanisation
- To incorporate gender equality and social inclusion (GESI) in all dimensions of development

- To manage population data, study, research, survey, and analysis and make them more effective
- To make the active population more productive and industrious for increasing national productivity

Number of policy statements: 9 (as focus areas)

Statements
1) Establish coordination and cooperation among stakeholders by considering population management as an important part of overall development in order to maintain interdependence between population and development 2) Develop reproductive health services including sexual health, family planning, and safe abortion as a rights based programme 3) Build an appropriate lifestyle and environment for a healthy livelihood 4) Effective management of immigration, emigration, and urbanisation 5) Improve the policy, laws, and institutional arrangement to mainstream population and development through inclusion of disadvantageous groups (on the basis of gender, sexual, lingual, economic, social and regional basis) and differently- abled people 6) Strengthen the institutional structure for policy formulation, programme design, implementation, and M&E in the population sector 7) Utilise information technology in research and analysis of interrelationship between population and development to provide feedback to concerned agencies for policy formulation and programme designing 8) Formulate developmental projects and programmes only after studying their demographic effects, and implementation of those on the basis of their justification on suitability 9) Utilise the demographic dividend specially the young people in employment related activities

Review

- The policy contains nine focus areas and 78 strategies.
- A twenty year (up to the year 2034) target for ten indicators related to health and population has also been set out in the document.
- The document is heavily focused on governance and does not properly address human resources, laboratory and pharmaceuticals, and financing aspects from a building blocks perspective.
- From an NHSS strategic perspective, it is more focused on equity.
- The policy statements cross-cut all three levels of government with no specificity.
- Organisational responsibilities as per the policy statements are also assigned, however, in the absence of an implementation plan, its implementation status could not be reviewed.
- At least a couple of policy statements are a repetition of objectives.
- As in some other policies, the population policy also has not addressed some of the problems listed in the policy document.
- As the responsible ministry for population matters have been shifted many times from one ministry to another. Recently, population has again merged with the MoHP resulting in the Ministry of Health and Population. It has affected the implementation of the policy. In the federal context, its relevancy needs to be revisited as per the constitution and needs to be

reformulated. At present, the homework for revision of the policy has already begun in the concerned ministry.

A1. 5 Urban Health Policy, 2014

This policy bases itself on the premises of the NHP, the provision of the Interim constitution, millennium development goals (MDG), Local self-Governance Act (2055) and a document named "A Collaborative Framework", signed jointly by secretaries of Ministry of Health and Ministry of Federal Affairs and Local Development (MoFALD).

Goal

To improve the health status of the urban population, especially of women, children, poor, and marginalised groups to contribute towards poverty alleviation.

Objectives

To increase access to quality basic health services (QBHS) and utilisation of services by communities and urban residents especially by women, children, and poor and marginalised groups.

Number of policy statements: 6

Statements
1) Provide QBHS to increase access for those living in urban areas, especially women, children, poor, and marginalised groups and the elderly population through modern Ayurvedic, Homeopathic, Unani, and alternative medical systems
2) Develop and scale up integrated urban health programmes to address the issues adversely affecting the health of women, children, poor, and marginalised groups and the community
3) Clarify roles and responsibilities of the organisations involved in urban health programmes to ensure uniformity in the delivery of basic health services and quality assurance of curative services
4) Promote capacity building, community participation, and empowerment of the concerned institutions for an efficient management, fair distribution and proper utilisation of basic health services in urban areas
5) Establish an effective mechanism for monitoring and evaluation, regulation, studies, and research concerning the services of urban health programme
6) Management and mobilisation of the resources required for the implementation of Urban Health Policy

Review

- The policy was approved when the interim constitution was in place, new constitution was being drafted. The basis of the policy is the health policy of 2014. Each policy statement is followed by strategies.
- It specifically focuses on health service provision in the urban areas. In the present context of having 293 urban municipalities and considering the assignment of functions to local government, such policies can be developed by local governments.
- It brings the issue of QBHS but the components of quality are not defined.
- The policy focuses more on governance and statements are directed to federal functions, however, the policy statements are more relevant for the local level in the changed context.

- A draft of the revision in the policy was also prepared and submitted to the Cabinet, however, it has not been approved yet.
- In addition to urban health centres, urban health promotion centres are also being established in various urban municipalities.
- An implementation plan of the policy was also prepared in 2016; (after two years of policy approval), however the MoHP has not approved the plan yet
- In the changed context, the implementation aspect of policy is becomes unclear, mainly because the overall governance structure has changed, the local self-governance act is replaced; therefore there is a need to review the policy in the changed context.
- The first urban health policy was developed in 2010.
- This can be considered as a sub-set of the NHP, as it deals with service provision in the urban area.

A1.6 National Health Insurance Policy, 2013

The then Three Year Development Plan (2010/11-2012/13), the NHSP II and corresponding annual workplan and budgets (AWPBs) have stressed the need of national health insurance policy to improve the health outcome of Nepalese people. The policy was deemed necessary to increase accessibility to, and equity in the provision of health care services by removing financial barriers to the use of health care services. Furthermore, rationale of this policy was to promote pre-payment and risk pooling mechanisms to mobilise financial resources for health in an equitable manner among others.

Objectives

The main objective of this policy is to ensure universal health coverage by increasing access to and utilisation of necessary quality health services.

Specific objectives

1. To increase the financial protection of the public by promoting pre-payment and risk pooling in the health sector
2. To mobilise financial resources in an equitable manner
3. To improve the effectiveness, efficiency, accountability, and quality of care in the delivery of health care services

This policy has not spelled out specific policy statements as such. However, there are strategies defined under each of the objectives which are listed in the table below.

Number of policy statements: 16 (as strategies)

Statements
1) Reduce out-of-pocket expenditure at the time of health service use
2) Pool and allocate funds in an equitable manner
3) Mobilise local community groups to increase the participation of the general public in the programme
4) Implement various interventions and activities to gradually improve the health seeking behaviour of the people
5) Be gradually expanded to cover the whole nation

6) Promote prepayment by collecting contributions from households
7) Receive specific funding to ensure the participation of poor and target population groups
8) Receive additional resources to enable it to be initiated and implemented in a sustainable manner
9) Cover every household in Nepal
10) Introduce provider payment mechanisms
11) Integrate existing social health protection interventions and programmes into the Health Insurance Programme, as feasible
12) Develop a national framework to integrate government supported health insurance initiatives and promote complementarity with other private insurance schemes
13) Promote the participation of governmental, non-governmental, and community organisations and public-private-partnerships
14) Motivate health workers and facilities to provide quality health services
15) Develop a system to control moral hazards and other risks that may arise in relation to service providers and service consumers
16) Promote output-oriented expenses

Review

- The overall thrust of the policy is to enhance financial protection against ill health mainly through the prepayment and risk pooling mechanism.
- This is the first policy in health that introduces the concept of collecting contribution from the households in a prepaid manner.
- It has an overall ambition of universal health coverage though the focus is on ensuring the participation of poor and target population
- The policy has also proposed an autonomous entity for the management of health insurance scheme as an institutional arrangement for the implementation.
- The policy has mentioned integrating the existing social protection schemes into the health insurance and public-private partnership but remains less pronounced as regards to the provision of health services.
- Although it focuses on system reform and equity aspects, it also covers quality of care and multi-sectoral collaboration and hence well aligns with the strategic directions of NHSS.
- This policy defines centralised governance structure for the management of the health insurance scheme and has less clarity on the role of different governments in the federal context.
- There is less clarity on the interface of health insurance with basic health services which are to be provided free of charge as per the constitutional provision and service delivery is the mandate of the local government as per the functional analysis.
- As per the policy thrust, the health insurance programme has already been implemented by establishing a semi-autonomous body called the 'Social Health Security Development Committee'. However, as promised in the policy, an autonomous entity named as the 'National Health Insurance Fund' was supposed to be established.
- Furthermore, the Health Insurance Act has been enacted by the parliament in 2017 which upholds the policy spirit.

A1.7 National Oral Health Policy, 2013

The policy was approved in 2013 (2070 BS) and it replaces the oral health policy of 2004 (2061 BS). The policy states that in order to improve the status of oral health of Nepalese people, the 2004 policy needs to be revised.

Goal

To enhance the quality of life and total reform through developing oral health status of the Nepali population.

Objectives

- To promote oral health and control diseases
- To ensure everybody's access to oral health
- To prioritise continuous surveillance, M&E, and research
- To prioritise oral health in health policy and system
- To develop partnerships with other sectors for development of oral health
- To strengthen the health system

Number of policy statements: 31

Statements
1) Develop a strategy tailored to the high risk population for the control of oral health diseases
2) Promote an oral health friendly environment at schools, workplaces, and the community sector
3) Strengthen primary oral health and sanitation programmes in coordination with the Ministry of Education
4) Promote every citizen to follow the oral health related information materials
5) Disseminate oral health related knowledge through NHEICC for behavioural change
6) Ensure the availability of quality and equitable oral health at all levels through integrated oral health programmes including the required resources
7) Develop primary health service systems through sustainable financing
8) In line with the implementation and monitoring activities of oral health, mobilise the community for promotive and control activities
9) Raise professional and social awareness at the local and national level
10) The MoHP will be responsible for the implementation of this policy
11) The proposed objectives will be achieved within ten years of implementation of this policy and no additional financial resources will be required to implement this policy
12) To prioritise continuous surveillance, M&E, and research
13) Initiate the establishment of the Nepal Medical and Dental Council to assure quality education in dental colleges and professionals
14) Promote responsibility and ethics in the oral health profession by establishing a legal and policy framework
15) Utilise evidence based research findings for information management and decision process
16) Ensure effective M&E by the stakeholders through collection of information from all levels from integrated health information management system
17) Include oral health and its contributing components in the national health policy and public health programmes of the MoHP

18) Develop appropriate integrated oral health policy incorporating planning and management aspects based on the analysis of the risk factors and appropriate information system
19) Improve the health status of the Nepali citizens through the involvement of different levels and sectors and addressing modifiable risk factors as oral health is an inter-sectoral issue and requires partnership even with external sectors
20) Ensure coordination and collaboration between ministries and other concerned government authorities to strengthen the health system
21) Develop an oral health plan and management through the development of integrated, relevant, and appropriate information systems including the analysis of risk factors
22) Implement oral health programmes in an economic manner considering the establishment of necessary infrastructure and supply management
23) Ensure safe, high quality, and acceptable diagnosis services by developing skilled professionals on oral health at all levels
24) Develop and utilise appropriate human resources that can fulfil the needs of the population
25) Develop legal provisions for oral health professionals
26) Develop quality dental education and professionals
27) Mobilise and strengthen public health through evidence based policies, advocacy, and decisions
28) Provide orientation to primary health care workers on oral health
29) Develop human resources for oral health
30) Motivate dental college to serve at district and community level through public private partnership
31) Establish super-specialised hospital at the central level on oral health

Review

- The initial oral health policy of the GoN (2004) (although it was named as policy, it was really a strategic plan) has been replaced by the existing Oral Health Policy, 2013. It has six objectives, followed by policy statements, to meet each of the objectives.
- The document has set six targets for ten years (up to 2024).
- From the health system building block perspective, it has mentioned all the themes except equipment and pharmaceuticals.
- The policy also contains some contradictory statements. For example, in one policy statement, it mentions that no additional funding is required to implement the policy. However, in contrast, the section on financing sources highlights that additional government funding is required to improve the status of oral health in Nepal. However, it does not suggest specific measures to generate additional resources.
- From the perspective of NHSS strategic directions, it focuses more on system reform.
- In the present context, the policy needs to be revisited. Alternatively, developing standards or SOPs is required to update the policy in the changed context.
- The Management Division of the DoHS is entrusted to guide oral health services.
- This is a sub-sectoral policy dealing with the oral health services.
- Although it will still be early to evaluate the policy based on its implementation, in the absence of action plan it is not easy to review properly.
- Oral health service could be incorporated in the package of basic health services as an approach of integrated health service delivery.

A1.8 National Health Laboratory Policy, 2013

This policy was formulated to support the national effort to achieve health related MDG targets, to implement Nepal's commitment to International Health Regulations (IHR, 2005), to develop infrastructure related with technical, physical and human resources and to engage the private sector in this field. The new policy demands for strengthening of laboratories which will help in diagnosing various diseases, including zoonotic and food-borne, and thereby help in disease surveillance, prevention, and treatment, including the promotion of health and research.

Goal

To increase access to quality laboratory services provided by the health laboratories of the government and the private sector in an effective and coordinated way.

Objectives

- To strengthen and expand the health laboratory services up to the local level for timely identification, diagnosis, treatment, and prevention of diseases
- To conduct and manage laboratory services by developing quality laboratory system
- To develop quality standards and regulatory mechanisms for the registration of laboratories
- To collaborate and carry out research in laboratory services

Number of Policy Statements: 12

Statements
1) The organisation and institutional framework for health laboratories will be developed and strengthened.
2) A regulatory mechanism will be developed for the availability and conduction of laboratory services.
3) The infrastructure, equipment, and maintenance of laboratories will be strengthened.
4) The maximum use of available human resources and continuity of services will be ensured along with human resource and capacity development.
5) Good laboratory systems will be practiced through inspection of laboratories and measuring the standards of testing procedures.
6) An information management system will be developed for integration of information on health services and laboratory services.
7) Contaminated materials from laboratories will be managed effectively for environmental safety.
8) A laboratory safety system will be implemented to ensure confidentiality between service providers and service receivers.
9) Financial resources will be mobilised and used to manage health laboratories.
10) An inter-agency mechanism will be developed to coordinate and collaborate among stakeholders running health laboratories.
11) Research and studies will be carried out on prevailing and emerging infectious and non-infectious diseases in the health sector
12) Concession on the laboratory tests will be provided to the destitute citizens along with addressing GESI in laboratory services as instructed by the GoN

Review

- This is the first policy on health laboratories. Prior to this the 'blood policy' used to govern this sub sector.
- The policy statements focus on governance, such as regulation of laboratories, laboratory safety systems, inspection of laboratories, information systems, infrastructure, gender mainstreaming, and research.
- The categories of laboratories are not in line with federal context.
- The policy does not specify the accreditation body and its regulation.
- This policy could qualify as a sub-sectoral policy dealing with health laboratory services.
- The policy is comprehensive in trying to address other health system building blocks like services, human resources, information systems, infrastructure, equipment, and financing within the context of strengthening health laboratory services.
- The policy emphasises strengthening and expanding the services up to the local level which is in line with the functions assigned to the local level as per the FAA.
- The policy statements are more equivocal. The policy talks about providing concessions to destitute citizens which is in line with the equity aspects of the health sector strategic directions.
- Various tiers of health laboratories have been proposed in the policy.
- The policy does not explicitly mention the multi-sectoral approach, however it does call for stakeholders' collaboration in laboratories.
- The policy's "stand alone" status needs revisiting keeping in view other acts, regulations, health services, and the entire quality of care domain.
- In the changed federal context, the policy needs to be revisited.
- A standard or SOP could replace this policy.

A1.9 National Health Communication Policy, 2012

The policy was developed in 2012 to improve access to and utilisation of essential health services particularly by those living in remote areas and by disadvantaged, poor, and marginalised populations. Nine specific rationale are given for the development of the policy, however in general the main rationale for developing the policy is to ensure quality, accuracy, reliability, uniformity, and appropriateness in health messages, information, and materials.

Goal

The main goal of the national health communication policy is to sustain healthy lifestyles of Nepal's citizens by promoting health services, programmes and healthy behaviour by preventing and controlling disease and by increasing accessibility to and utilisation of health services.

Objectives

- Mobilise and use modern and traditional communication multimedia and methods in an extensive and proportionate manner to raise health awareness, knowledge, and promote the healthy behaviour of mass citizens
- Strengthen, expand, and implement health communication programmes at the central, region, district, and community level through clear and strengthened cooperation, coordination, and collaboration among individuals, the community, relevant organisations, and communication media

- Generate, collect, and mobilise sufficient resources for the effective implementation of health communication programmes at the central, regional, district, and community level
- Prevent unauthorised dissemination and duplication of health related messages or information and materials on different issues by maintaining quality, correctness, authorisation, uniformity, and appropriateness
- Enhance capacity on health communication in order to develop, produce, and disseminate quality, correct, authorised, uniform, and appropriate messages or information, materials, and programmes
- Provide quality health messages or information through appropriate media and methods to the citizens, who have no access to health messages or information

Number of policy statements: 20

Statements
1) Implement health communication programmes in a decentralised manner
2) Provide continuity to working in planning and the implementation of communication programmes of all health services and programmes in an integrated approach and through a one door system
3) Allocate at least two percent budget annually of the total annual budget of MoHP annually for managing adequate financial resources to implement health communication related programmes
4) Promote the participation, coordination, and cooperation of relevant organisations and stakeholders for effective implementation of health communication programmes
5) Use extensively modern and traditional multimedia especially mass, interpersonal, and social communication media and methods based on the appropriateness to disseminate health messages or information
6) Make arrangements for the dissemination of health messages or information based on need, approved standards, and classification through all communication media and methods to intended audiences by direct negotiated agreements in a transparent and proportionate manner
7) Disseminate health messages or information in an educative, artistic, and entertaining manner in local languages and in a culturally appropriate manner
8) Prevent the dissemination of health messages or information without taking pre-consent from GoN by making necessary arrangements for maintaining quality, correctness, authorised, uniformity, and appropriateness, avoiding duplication and making policy based health messages or information
9) Make arrangements to encourage communication media, institutions, health workers, journalists, or health issue centred communication media, which has made a significant contribution to disseminating health messages or information
10) Encourage and facilitate dissemination of health messages or information or materials through different communication media and methods in public private partnerships under corporate social responsibility
11) Regulate, control, and ban the dissemination of any types of messages or information that can adversely affect human health, are exaggerated, of a misled nature, and unauthorised
12) Make transparent and informed decisions by disseminating health services, programmes, proper use of medicines, and medicine and service charges provided to people by governmental, non-governmental, and private organisations
13) Make arrangements to obtain health message or information or materials easily by physically

and mentally disabled persons and senior citizens

14) Give priority to issues related to control lifestyle related diseases and encourage improving daily lifestyle of human from simple behaviour of individuals
15) Ensure good governance and management of health services and institutions of all levels for effective planning and implementation of health communication programmes by building capacity of health promotion and communication
16) Provide quality health messages or information to mass citizens, particularly people living in remote villages with no access and geographically, ethnicity, and gender wise disadvantaged, poor, and marginalised populations in an appropriate time and from appropriate media and methods
17) Link health messages or information and programmes with services and these health messages or information will be socially inclusive, gender friendly and rights, fact, and audience based
18) Promote and use advanced modern communication technology for the dissemination of health messages or information
19) Emphasise quality health promotion and communication by developing and producing manpower related to health promotion and communication
20) Develop and use an M&E mechanism for the overall use of message and materials and the effectiveness of the programmes related with health communication

Review

- The policy statements are followed by a number of 'strategies or action policies'.
- The policy prioritises health promotion, education, and communication programmes in the health sector.
- The policy opens the avenue of health communication in the decentralised context, however it does not mention anything specific to the roles of different levels.
- The policy promotes an integrated approach to health communication.
- The policy acknowledges the cultural and language diversity and the need to tailor information accordingly to reach all.
- In the light of constitutional provision of "right to information" and the mention of counselling in health care, the legal aspect might need to be considered.
- Access of health information by marginalised and vulnerable groups is focused on, ensuring equity perspectives.
- The policy touches upon the governance aspects in terms of regulating the dissemination of harmful messages.
- The document explicitly mentions capacity building on health promotion.
- The policy promotes the use of advanced technology including multi-media for dissemination of health messages.
- There is an emphasis on ensuring quality of health messages and information.
- A number of committees have been proposed to effectively implement the policies.
- No implementation plan is yet formulated on the basis of this policy.
- From a health system building blocks perspective, the policy is more focused on health information and health services with particular focus on the demand side.
- From the perspectives of strategic directions of NHSS, it focuses more on system reform.
- From the federal perspective, the majority of the statements are equivocal for each level of government.

A1.10 National Policy on HIV and STI, 2010

The first policy, named the National Policy on AIDS and STD Control, was developed in 1995 (2052 BS). Based on this policy, three strategic plans were implemented guiding the overall implementation of programmes in the HIV/AIDS and STI sector. As a result, HIV infection prevention and control programmes are being conducted in high risk groups as well as in other related sectors. However, considering the great changes in the prospect, situation, infection rate, perception towards HIV, and in the changed political context, the new national policy on HIV and STI was developed in 2010.

Goal

The goal is to ensure the right of Nepalese citizens to live healthy lives by reducing the HIV infection rate and its negative impact.

Objectives

- Reduction in HIV infection by creating an environment appropriate for prevention, treatment, and care
- Protect and promote the human rights of the affected and high risk group people by abolishing the negative values, stigma, and discrimination related to HIV/AIDS

Number of policy statements: 27

Statements
A. Policy development and plan formulation
1) HIV/AIDS and STI control, prevention, treatment, and care shall be given high priority in the state plan and policy for this purpose.
2) Meaningful involvement of HIV infected and high risk community along with external development partners, donor countries, and other stakeholders shall be ensured. In addition, the mainstreaming of HIV awareness shall be encouraged in the plan and programmes of the international organisations and donor agencies.
3) HIV/AIDS programmes shall be launched through health service providers and other organisations after formulation of quality and credible health service standards.
4) Special programmes for HIV infected and affected women and children shall be launched by adopting the principle of gender inclusion.
B. Prevention, diagnosis, treatment, and care
5) Information about HIV and AIDS shall be included in the formal and informal education curriculum in an organised way.
6) Awareness programmes about safer sexual behaviour and HIV/AIDS shall be launched.
7) A policy and plan on HIV and AIDS shall be implemented at workplaces with the partnership of private sectors.
8) After identifying the groups at risk and most at risk behaviour, co-ordinated programmes about prevention, diagnosis, treatment, and care as well as risk reduction, health preservation, and promotional materials shall be launched.
9) Quality services for the prevention of mother to child transmission (PMTCT) shall be expanded in the whole country.
10) Target-specific programmes shall be launched after identifying the possible risk groups.
11) Policy, plans, and programmes related to HIV/AIDS shall be implemented in coordination

Statements
with the policy, plans, and programmes of the health and other sectors. 12) HIV shall be gradually integrated into the reproductive health, child health and tuberculosis control and other programmes conducted at different levels of health institutions from the centre to grassroots. 13) A multi-sectoral HIV/AIDS strategy shall be developed and implemented to extend HIV/AIDS issue beyond health sector at the present stage. **C. Risk Reduction** 14) Universal precautions and control programmes and post exposure prophylaxis measures shall be effectively applied among the health care providers. **D. Rights and Confidentiality** 15) Mandatory HIV testing shall not be applied however prior testing for HIV shall be made compulsory before donation of body fluids and organ transplantation. 16) Confidentiality about HIV testing shall be maintained. The confidentiality of HIV positive and affected people shall be maintained in the medical and legal process. Legal arrangements shall be done to protect the rights of HIV infected and affected people. **E. Rehabilitation and socialisation** 17) Programmes related to rehabilitation, livelihood, career development, and social security of HIV positive and affected people as well as high risk group shall be conducted. **F. Bilateral, Multilateral or sectoral efforts** 18) Bilateral, multilateral, or sectoral efforts shall be enhanced to address issues related to HIV/AIDS within the country. **G. Institutional Arrangement** 19) A high level "National AIDS Council" shall be there to provide instructions and guidelines for the multi-sectoral response about HIV/AIDS under the Chairpersonship of the Prime Minister. 20) A “HIV/AIDS and STI Control Board" shall be formed as the Secretariat of the "National AIDS Council", as stated in the Annex 2, for formulation of the national HIV/AIDS policy and strategy, comprehensive co-ordination of the multi-sectoral responses, M&E of the national responses, and mobilisation of the internal and external resources. 21) A "National Centre for AIDS and STD Control” (NCASC) shall be there under the MoHP to prepare action plan, execute, coordinate, and monitor the health services related to HIV/AIDS. This centre shall execute its programmes through central, regional, zonal, and district level health facilities, district health and public health offices, health centres, health posts, and sub-health posts. 22) Female Community Health Volunteers and other health service providing organisations and institutions. 23) The mainstreaming of HIV/AIDS shall be executed by establishing HIV and AIDS Focal points (desks) in the Prime Minister Office, National Planning Commission, and the line ministries. 24) A HIV/AIDS Coordination Committee shall be formed at district, municipality, and village development committee level to coordinate HIV/AIDS and STI control programmes for implementation. **H. Research and study** 25) A system shall be developed to collect, analyse, and utilise the reliable data related to HIV/AIDS and Sexually Transmitted Infections (STI). 26) Research and study about social, economic and human aspect of HIV/AIDS and STI shall be

Statements
conducted according to the guidelines prepared in consultation with the HIV/AIDS and STI Control Board and NCASC. **I. Community Based Programme** 27) Local Bodies shall be made responsible for the HIV/AIDS and STI control responses and local Non-Government Organisations, Civil Societies, and the community shall be mobilised for execution.

Review

- This policy is the revised version, the first policy named National AIDS Policy was published in 1995.
- This policy has established the policy and governance framework for Nepal's responses to HIV and STIs.
- After this policy, in 2011, two periodic strategies have been developed. The first was the National HIV Strategy 2011-16 and the second is the National HIV strategic plan 2016-2021. In the series of developing and implementing the strategies, the first strategy was developed in 2006. So the latest strategy is the third strategy in the sector.
- The policy takes into account the rights based approach and the free basic health service as envisioned in the then Interim Constitution of Nepal.
- As a result of implementing the policies and strategies, Nepal was able to achieve the MDG target related to HIV, the trend of spreading AIDS is halted and reversed. The number of AIDS related deaths has also started to decline.
- A major challenge for the sustainable implementation of the policy is that this particular sub-sector is very much dependent on foreign aid (almost 90%, as quoted in National HIV strategic Plan 2016-2021).
- From a building blocks perspective, this policy deals with governance such as multi-sectoral coordination, HIV testing, HIV positive persons' rights, mainstreaming the programme, and system development.
- As a result of the policy provisions, various activities have been carried out to ensure services for HIV are expanded to various places, many committees have been formed and surveillance and research has been regularly conducted.
- Most of the areas covered in the policy are also stipulated in NHSS.
- The policy places emphasis on system reform such as meaningful involvement of HIV infected persons, the formation of different committees, and data generation and use.
- The service delivery functions as highlighted by different policy statements will essentially be the role of local level in light of the BHS as defined in NHSS.
- Many of the policy statements are too specific such as the activities section.
- The services could be part of primary health care along with good referral system.

A1.11 The National Health Research Policy, 2010

The National Health Research Policy (NHRP) was originally developed in 2003 and was later revised in 2010. The latest policy strives for the achievement of better health for all through health research with an emphasis on equity, social justice, and ethics. It further highlights that research should serve

as the “brain of the health system,” providing evidence for the direction that the national health system should take. The policy stresses that consideration should be given not only national but also international community to improve research governance and stewardship and strengthen essential public health functions.

Objectives

- To promote health research culture in the country
- To enhance the capacity in health research in the country
- To conduct the health research for generating the evidences for health policy and planning
- To promote networking and collaboration in health research in the country
- To develop synergy in health research development in the country
- To communicate the research findings to health policy makers and stakeholders
- To implement ethical norms and standards in health research in the country

The objectives of the policy are followed by the following aims:

- To align the national health research policy to national health policy
- To generate evidence from research that can be used to strengthen efficiency and effectiveness of the health system
- To build national health research capacity including that of academia, research institutions, health service institutions, and the community to conduct health research and utilise the findings for programme/services development
- To promote health research culture in academia, research institutions, the DoHS, and creating an ethos of evidence based decision making amongst senior level civil servants and policy makers
- To emphasise ethical practices in health research
- To promote health research in the broad dimensions–biomedical, clinical, social sciences, public health, health economics, Traditional Complementary and Alternative Medicine (TCAM), and health policy research
- To develop a mechanism for effective communication of research to ensure that the benefits of research are effectively translated into practice
- To generate and mobilise financial resources for health research, capacity development and NHRS strengthening
- To promote national and international partnership collaboration and networking in health research

Number of policy statement: 1

Statement
The NHRP of Nepal strives for the achievement of better health for all through health research with an emphasis on equity, social justice, and ethics

Review

- The policy was developed in accordance with the provision of NHRC Act 1991 6 (b) which governs the research relating to health and passed by NHRC Board.
- The policy is focused on health research and limits its scope as cross-cutting policy.

- A total of six strategies and working policies are listed in the NHRP and a number of working or operational policies for accomplishing policy aims are also mentioned in the NHRP.
- As it is the policy on health research, it extensively elaborates different aspects of health research.
- The policy focuses on research, capacity building, finance, and administration in health research and accordingly proposes an institutional structure for the NHRC. However, in the changed federal context such a structure needs to be revisited.
- It primarily captures fives aspects of research: the generation of evidence, promotion of health research, ethical practice, and collaboration and networking in health research.
- The National Health Research Council is carrying out various research activities as per the mandate of the policy and the corresponding Act.
- Being a policy of the regulatory body, the policy concentrates on the regulation and promotion of health research.
- It is imperative that the policy needs revision in light of the functions of different levels of government as per the functional analysis.
- The policy was approved by the NHRC Board itself, not by the Cabinet of Ministers.

A1.12 Policy on Quality Assurance in Health Care Services, 2007

This policy developed in 2007 (2064 BS) notes that progress was observed in reduced infant and child mortality, reduced prevalence of vaccine preventable diseases, and increased utilisation of essential health care services. However, it notes that the desired outcome cannot be expected without assuring optimum quality of services. It refers to the medium term strategic plan which suggested improving quality of health services in public, private, and NGO sectors through total quality management. It also refers to NHSS (2004) for a stress on establishing service protocols and quality standards. The scope of the policy is quite broad in the sense that it covers the quality aspects in the health care services.

Goal

- To ensure the quality of services provided by governmental, non-governmental and private sector according to a set standard
- An autonomous institute will be established to ensure the quality of education provided for health care service providers working in governmental and non-governmental sector

Objectives (as purpose)

- To provide strategic guidelines for the integration of quality of care components in all health services specially in essential health care services
- To ensure that a quality assurance system is in place and overall quality improvement activities are well implemented in all health facilities to fulfil client's needs

Number of policy statements: 3

Statements
1. Quality assurance will be developed as an integral part of the essential health care services delivery system.
2. A coordination mechanism will be developed among NGOs, the private sector, and the local community to ensure quality health service delivery.

3. A sustainable standard will be developed from the central to the district level in order to monitor the quality assurance services.

A total of 17 strategies are followed by the policy statements. Various quality assurance committees are also provisioned in the policy.

Review

- This policy is very much limited with its policy statements, though it covers a broader area of influence.
- This policy specifically deals with the issue of quality, which is cross-cutting but it does not talk explicitly about quality as an integral component of health system building blocks.
- How the information management system relates to quality is not explicit.
- The policy stresses system reform to ensure quality of care.
- Various Committees, as proposed in the policy, have been formed and orientation to stakeholders on minimum service standards has been carried out.
- There is a disconnection between the goal of the document and the policy statements. For example, there is no policy statement to address the goal of "quality of education provided for health care service provider".
- From the federalism perspective, it is more equivocal in nature. However, the policy needs to be revisited once the structure for health at three levels is approved and there is clarity on the governance of quality assurance for the three levels.
- To ensure quality in delivering health services, the development of standards and SOPs are critical with an emphasis on strong governance mechanism.
- The policy is not explicit on the information management system in relation to quality.

A1.13 Health Care Technology Policy, 2006

This policy was developed in 2004 which acknowledges that the use of health care technology is far from at a satisfactory level due to the inefficient use of equipment and facilities. Furthermore, it mentions different issues in the health system with regards to the use of health care technology such as unscientific and ad-hoc procurement, improper storage and manipulation of sensitive equipment, and poor compliance to safety standards.

In the country-wide context, the policy highlights the importance of using appropriate technology for effective delivery of healthcare services while increasing the returns on investments.

Objectives

- Promote and regulate appropriate technologies and establish supportive systems
- Improve policy, planning and procurement procedures for medical devices, utilities and facilities
- Ensure conditions for appropriate human resource development
- Improve outcomes of utilisation of equipment and related services
- Promote economic use of HCT and thereby increase returns on the investments
- Promote good clinical practices including safety aspects and risk management

Number of policy statements: 11

Statements
1) Appropriate and sustainable organisational structures at all levels of the health system will be established and adequately supported to support health care technology.
2) Rational, informed, and appropriate strategic planning, the macro- and/or micro-assessment of healthcare technologies and their management will be introduced taking into account the general situation of the resources available, system constraints, and technology transfer issues.
3) Proper and effective selection, procurement, and commissioning of HCT with due consideration to the cost-of-ownership issues, human resources, and infrastructural requirements as well as organisational capabilities will be actively encouraged and supported.
4) Assets will be utilised effectively and equitably with due consideration to life-cycle costing issues as well as ensuring a safety net for poor people.
5) The availability of healthcare technology resources will be optimised within the given economic constraints but adequate stress will be given to ensure sufficient budgetary allocations for technology management and maintenance activities.
6) The country's total healthcare technology resources will be utilised to their fullest capacity through a mutually beneficial arrangement between the public and private sectors.
7) Existing legislations, regulations, and incentives will be consolidated and new instruments developed where required, to ensure proper acquisition including procurement and commissioning, safe, and effective utilisation of healthcare technologies.
8) Research leading to improved implementation and M&E of the HCT policy and improved management systems will be conducted. National self-reliance in identified areas of health technology will be promoted. Appropriate incentives will be provided to encourage the use of indigenous technology for health care.
9) An integrated system for appropriate and effective data collection, storage, and analysis as well as the dissemination of information and knowledge in support of HCT and physical assets will be developed and maintained.
10) The Government will recognise and promote the important role of stakeholders including those of the development partners, technical agencies, private sector, and NGOs.
11) The healthcare technology policy will be integrated into other national policies to establish mechanism monitoring and evaluation of the performance of health care technologies. A strong regulatory mechanism will be established to ensure the effective implementation of HCT policies.

A number of strategies are followed by the policy statements. It was also promised in the policy that the policy will be reviewed at five year intervals.

Review

- The policy is comprehensive to covering a wide spectrum to promote the appropriate use of health care technology to maximise returns of the investment made.
- The policy does not address the health technology assessment, which is evidence based, for new technology.
- The document captures governance, financing, human resources, information systems, and service delivery dimensions including the regulatory and institutional aspects and it even touches on the decentralisation perspective.

- It focuses on the medical equipment and devices while being less explicit on the pharmaceutical products including vaccines and other supplies.
- The policy captures system reform and multi-sectoral collaboration related aspects but hardly touches on quality on equity dimensions
- As a result of policy provisions, Physical Asset Management (PAM) is functional and contract for maintenance of medical equipment is being done.
- Revision of this policy seems imperative in light of the current discussion on quality assurance and accreditation. Organisational restructuring and assigned function technology needs re-examining.
- This could be a part of overall Health Services Act.

A1.14 National Policy on Skilled Birth Attendants, 2006

This policy was developed in 2006 as a supplementary policy to the National Safe Motherhood Policy (1998). It mentions that the proportion of births assisted by skilled birth attendants (SBAs) was used as a key indicator for assessing progress towards maternal mortality reduction as the fifth goal of the MDGs. It stresses that Nepal, as a signatory of the MDG declaration to meet the target, needed to develop their respective policy. The policy states that only 13 percent of women were attended by health workers during delivery and not all the health workers were qualified as SBAs. With this backdrop, the policy was developed to meet the target of 60 percent of deliveries assisted by SBA by 2015.

The scope of the policy is limited to the production, utilisation, and regulation of SBAs in the light of achieving the MDGs and is mentioned as a supplementary to the National Safe Motherhood Policy of 1998.

General Objective: To reduce maternal and neonatal morbidity and mortality by ensuring the availability of, access to, and utilisation of skilled care at every birth.

Specific Objectives

- To ensure that sufficient numbers of SBAs are trained and deployed at primary health care levels with a necessary support system
- To strengthen referral services for safe motherhood and newborn care, particularly at the first referral level (district hospitals)
- To strengthen the pre-service and in-service SBA training institutions to ensure that all graduates will have the necessary skills
- To strengthen the supervision and support system to ensure that all SBAs are able to provide quality maternal and newborn health care according to the national standards and protocol.
- To develop regulating, accrediting, and re-licensing systems for ensuring that all SBAs have the abilities and skills to practice in accordance with the core competencies

Under the heading of SBA policy statement, it is stated that 'the main thrust of MoHP towards reducing maternal and neonatal mortality in Nepal, is through the Safe Motherhood Programme, including Newborn Care, by improving maternal and neonatal health services at all levels of the healthcare delivery system and ensuring skilled care at every birth'. This is the only policy statement in the document. This is followed by a number of strategies which are listed below.

Number of policy statements: 8 (as strategies)

Statements
1) Human Resources Development • Short-Term: Review of existing short term courses to include core skills for SBA for staff nurses/auxiliary nurse midwives (ANMs) and doctors • Medium-Term: Restructuring of the existing ANM, PCL, and BSc nursing, Doctor in Medicine, General Practice(MDGP) courses and obstetrics and gynaecological section of MBBS courses to include core elements of SBA skills • Long-Term: Initiate a new cadre of professional midwives 2) Strengthen SBA training sites through accreditation and expansion of SBA training sites 3) Prioritise the posting of ANMs with SBA skills to remote areas along with the provision of minimum staff at health posts and sub-health posts 4) Service provision: entails the provision of essential MNH care at PHCC level by SBAs and when complications occur, at the referral level (BEONC, CEONC sites) 5) Create an enabling environment through professional accreditation, licensing, and legal framework along with strong referral mechanism, supportive supervision, partnerships, and incentives 6) Develop a quality assurance system in collaboration with professional organisations and associations 7) Encourage non-government sector, private sector, and communities for the expansion of maternity hospitals and birthing centres 8) The Family Health Division will be the focal division and NHTC will take the lead for the development of SBA along with the reinforcement of the Ministry of Education and CTEVT

Review

- The policy is supplementary to the National Safe Motherhood Policy, 1998.
- The policy statements are defined mostly in the form of strategies.
- The main thrust of the policy is on the production of SBAs for providing necessary safe motherhood services and is driven by the target MDG to increase delivery by SBAs and so needs to be looked from SDG perspectives in future.
- The policy also largely focuses on governance to meet goals four and five of the MDGs.
- The policy talks about SBAs in silo without proper linkages with the wider area of Human Resources for Health.
- As per the policy provisions, a Midwifery course has been started by two universities, SBA Training sites have been developed and capacitated through various measures and SBAs are trained accordingly.
- The availability of SBA- trained nurses in remote areas has been ensured.
- Currently about 1700 birthing centres, including BEONC and CEONC sites, are operational across the country.
- The policy defines the role of the local level in the management of SBAs while FAA has assigned HR management functions to the federal and provincial level.
- The policy defines the minimum number of ANMs for the health posts and sub-health posts. In this context, recently in 2017, the cabinet has endorsed the integrated health infrastructure development standards which sets standards for different levels of health facilities. Furthermore, the provision of basic health services is now the mandate of the local

level. Therefore, revision to the policy in the changed context should address these recent developments.

A1.15 National Nutrition Policy, 2004

The National Nutrition Policy was originally developed in 2004 and was later updated in 2008 and renamed as the National Nutrition Policy and Strategy. It is one of the main documents that guides nutrition related programmes in the health sector. The policy states that the government was concerned about serious malnutrition that persistently existed in a large section of the population in different forms, degrees, and magnitudes. In order to control/reduce nutritional problems, various measures were based on the principles of human rights, preconditions for development, healthy life, universal primary education, prioritised groups, people's participation, and gender. On this basis, the policy states that it was an expression of strong commitment to improving the situation and ensuring the nutritional well-being of all of the population.

The scope of the policy is limited to nutrition related services in the health sector and does not address the production and distribution aspects of foods and food products.

Goal

The overall goal of the policy is 'achieving nutritional well-being of all people in Nepal so that they can maintain a healthy life and contribute to the socio-economic development of the country, through improved nutrition-programme implementation in collaboration with relevant sectors'.

Objectives

- To reduce protein-energy malnutrition in children under five years of age and reproductive aged women
- To reduce the prevalence Iron Deficiency Anaemia (IDA) of anaemia among women and children
- To virtually eliminate iodine deficiency disorders and sustain the elimination
- To virtually eliminate vitamin A deficiency and sustain the elimination
- To reduce the infestation of intestinal worms among children and pregnant women
- To reduce the prevalence of low birth weight
- To improve household food security to ensure that all people can have adequate access, availability, and utilisation of food needed for healthy life
- To promote the practice of good dietary habits to improve the nutritional status of all people
- To prevent and control infectious diseases to improve nutritional status and reduce child mortality
- To control the incidence of life-style related diseases (coronary artery disease, hypertension, tobacco and smoke related diseases, cancer, diabetes, dyslipidaemia, etc.)
- To improve the health and nutritional status of school children
- To reduce the critical risk of malnutrition and life during exceptionally difficult circumstances
- To strengthen the system for analysing, monitoring, and evaluating the nutrition situation

Each of these objectives was followed by a number of targets. There are no policy statements as such. Instead, there are 11 general strategies and strategic approaches for nutrition which contain specific objectives and numerous strategies against each of the specific objectives. Each of these

specific objectives are accompanied with activities and responsible agencies to carry out the activities are mentioned in the policy.

Number of policy statements: 62 (as specific objectives)

Statements
Protein energy Malnutrition Control
1) To protect, promote, and support optimal feeding practice for infants and young children
2) To increase the coverage of Growth Monitoring (GM)
3) To improve nutrition knowledge, attitudes, and practices of parents and the community
4) To facilitate the building of nutrition rehabilitation institutions for severe malnutrition
5) To reduce the number of children who suffer from inadequate energy intake
6) To reduce low birth weight
7) To reduce the risk of infectious diseases
8) To improve maternal nutrition
9) To reduce the risk factors for under-nutrition in women, particularly pregnant and lactating women
Iron Deficiency Anaemia Control
10) To increase coverage and compliance of iron/folate supplementation for pregnant and postpartum women
11) To reduce the burden of parasitic infestations helminths, kalazar and malaria
12) To control vitamin A deficiency in children and pregnant and postpartum mothers
13) To effectively implement food fortification to increase dietary iron intake
14) To promote locally appropriate dietary modifications to improve the quality and diversity of food consumed
15) To promote maternal care practices to improve health and nutritional status of mothers and their babies
16) To identify effective modalities to address iron deficiency in children, adolescents and non-pregnant reproductive aged women
17) To develop a systematic approach to the M&E of anaemia control programme activities
Iodine Deficiency Disorder Control
18) To ensure all edible salt is iodized
19) To increase the accessibility of iodized packet salt with quality assurance logo
20) To increase the use of iodized packet salt
21) To monitor Iodine Deficiency Disorder (IDD) prevalence at national level
Vitamin A Deficiency Disorder Control
22) To sustain the existing high coverage of supplementation of high-dose VA capsules to children aged six to 59 months
23) To increase the coverage of supplementation of high-dose VA capsules to postpartum mothers
24) To reduce the risk of VA deficiency for night blind pregnant mothers
25) To ensure NS/CHD treatment of clinical conditions such as xerophthalmia, measles, severe malnutrition and prolonged diarrhoea by the recommended dose of VA capsules
26) To promote dietary modification to improve the quality and diversity of foods
27) To promote the use of VA fortified food
Intestinal Worm Control
28) To sustain the existing high coverage of deworming tablets among children aged one to five

Statements
years 29) To increase the coverage of deworming tablets for pregnant women 30) To promote the improvement of hygiene practices to reduce contamination with intestinal worms/ova 31) To sustain the existing high coverage of deworming tablets among children aged one to five years 32) To increase the coverage of deworming tablets to pregnant women.* **Low Birth Weight Control** 33) To improve maternal nutritional status 34) To reduce number of pregnant women who have the habits of smoking tobacco and drinking alcohol 35) To reduce cases of early pregnancy 36) To increase the percentage of pregnant women who access services for nutrition monitoring and counselling at antenatal clinics **Household Food Security** 37) To improve nutritious food production at the household level 38) To improve food storage and preservation skills 39) To diversify the utilisation of various food items 40) To improve food storage and preservation skills* 41) To diversify utilisation of various food items 42) To improve food allocation throughout the year within the household 43) To increase income generating opportunities for sustained purchasing power of foods **Improved Dietary Habits** 44) To identify nutritional problems due to culturally related dietary habits 45) To increase the awareness and knowledge of balanced diets, nutritious foods, and good dietary habits 46) To promote behaviour change to improve dietary habits 47) To reduce the risk of nutritional problems due to food taboos 48) To increase the availability of various types of food at the household level 49) To encourage women in the decision making for preparation of family foods **Infectious Diseases Control** 50) To reduce the risk of morbidity and mortality by infectious diseases **Life-style Related Diseases Control** 51) To promote good food habits 52) To promote better lifestyle for improved health 53) To reduce inadequate intrauterine development and malnutrition and obesity during childhood **School Health and Nutrition** 54) To Increase use of School Health and Nutrition (SHN) services by school children 55) To improve healthy school environment 56) To improve health and nutrition behaviour **Nutrition in exceptionally difficult circumstances** 57) To reduce the risk of malnutrition and morbidity/mortality by HIV transmission through Breast Feeding of infants 58) To reduce the risk of malnutrition and morbidity/mortality of people who suffer through

Statements
complex emergencies including natural or human-induced disasters (flood, drought, earthquake, war, civil unrest, severe political, and economic living conditions) **Analysing, Monitoring and Evaluating Nutrition Situation** 59) To strengthen existing institutional capacities and capabilities at various levels 60) To improve the coordination of data collection, analysis, and reporting 61) To standardise tools for M&E of the nutrition situation 62) To implement national survey to assess nutritional status in Nepal
*- Repeated statements

Review

- This policy was re-published in 2008 under the name "Nutrition Policy and Strategy"
- There are no policy statements as such, only objectives along with strategies are mentioned
- The documents presents itself as a plan with target and time line
- From a building blocks perspective, it focuses predominantly on governance and service
- It is more focused on system reform at the local level from the perspective of NHSS strategic directions
- In the context of federalism, it is predominantly equivocal across the levels of government
- Nutrition has been placed as a priority programme in Nepal
- The document is essentially a sub-sectoral policy dealing with nutrition related conditions
- The identification and proposal of some interventions in the health sector to impact the overall nutrition sector is a serious weakness of the policy
- It seems the policy does not sufficiently address the capacity gaps in the sector
- The policy does not cover the wider dimension of nutrition (from production and distribution perspectives) and is limited to under-nutrition and micro-nutrients
- Issues pertaining to food related behaviours, nutrition fortification, commercial food products, and markets are not addressed
- A multi sector nutrition plan (2013-2017) and multi sector nutrition plan (2nd) (2017-2021) has been developed and is being implemented. The policy needs to be revised in the changed context.

A1.16 National Safe Abortion Policy, 2003

The Muluki Ain, the basic legal code of Nepal, prohibited and characterised abortion as an offense against life, making no exception even when pregnancy threatened a woman's life until 2002 when the Muluki Ain was amended legalising the abortion services. The policy, developed in 2003, states that unsafe abortion was one of the major causes of high maternal mortality. It quotes various studies and research findings which show a strong relationship between abortion and maternal mortality rate. On the basis of the findings and in line with change in law, this policy was developed to provide safe abortion services. The scope of the policy is to establish safe abortion services in the country on the basis of existing laws.

Objectives

The policy does not define objectives as such, however, the essence of developing this policy is to make the abortion services safe and accessible.

Number of Policy Statements: 15

Statements
1) Comprehensive Abortion Care (CAC) services will be made safe, accessible, and affordable. These services will be made available with equity and equality for all women 2) Comprehensive abortion care services will be provided through service providers listed as per the Safe Pregnancy Termination Order 3) An effort will be made to offer a choice of available methods 4) The process associated with listing the institutions and individual practitioners authorised to provide CAC services will be made as simple as possible 5) Referral networks will be established between CAC facilities and more advanced referral centres where a higher level of care can be offered, including complication care 6) In order to maximise accessibility, CAC services will be expanded through GoN (the then His Majesty Government of Nepal HMG/N) semiautonomous institutions, NGOs and the private sector 7) Authorised CAC service providers performing these services in good faith will be protected under the law 8) Pregnancy termination shall not be used as a method of family planning 9) Pregnancy termination shall not be performed for the purpose of sex selection 10) Quality CAC services will be provided through a range of skilled service providers listed as per the Safe Pregnancy Process. Providers' professional conduct will be consistent with accepted medical standards and protocols 11) CAC services will be integrated with existing reproductive health and hospital services. CAC services as a component of the National Reproductive Health Strategy will be introduced in a phased manner with the ultimate goal of providing services at the Primary Health Care Centre level 12) Clinical protocols will be developed and will be the basis for CAC services and training. To update the skills and the competency of the service providers, further training as per the standard protocols will be provided. Counselling services, including family planning counselling, will be an integral part of the provision of CAC services 13) Traditional unsafe abortion providers will be encouraged to refer cases to skilled providers 14) Every institution and/or service provider should ensure that its fee structure for CAC services is transparent 15) Every CAC service site and referral service site will co-ordinate with each another to provide quality services

Under these headings, a number of strategy like statements are included in the policy.

Review

- The policy was developed just after the legalisation of abortion with focus on the delivery of services.
- This policy is a sub-sectoral policy dealing with the issue of safe abortion services.
- Besides a broader focus on service delivery, the policy concentrates on the rights of women, human resources, advocacy and awareness, coordination and monitoring, and institutional arrangements.
- Safe abortion services have been legally approved and the regulations to this effect have been made, various public and private health facilities are providing safe abortion services across the country.

- The policy does not address the screening and management of complications
- The policy focuses on working with I/ NGOs and the private sector along with an emphasis on a multi-sectoral approach.
- The policy is equivocal from a federalism perspective.
- The scope for the management and delivery of services needs to be redefined as per the functions assigned to the three levels of government. In the current federal context, mandates of the federal level are mainly setting policy framework and standards while the provinces have to manage services at the provincial level and local levels have to provide basic health services.
- As this policy was developed after having the legal base for abortion, the policy focuses on operational procedures which could be part of the SOP or operational guidelines.
- It focuses on the comprehensive abortion services in general and remains silent as regards new developments in this area such "medical abortion" though it just mentions "offer a choice of methods".

A1.17 National Vaccination Policy on Safe Injection, 2000-2001

This policy, developed in 2000-2001, deals with the use of auto-disable syringes in vaccination programmes. The topics covered are the "use of auto disable syringes, solvent syringe used for vaccine freezing in the cold (BCG, measles), and safe disposal of safe box and used syringes". The scope of the policy is to guide in the provision of safe immunisation services to the population.

Objectives
The policy does not define objectives as such.

Number of policy statements: 3

Statements

1) All vaccines are administered with auto disable syringes. The reusable syringes will be replaced by using the following syringes in regular and other vaccination programmes:
   - 0.5 ml syringe for DPT, Hepatitis B, measles, and tetanus
   - 0.1 ml syringe for BCG vaccination

   Solvent syringes are to be used for the following vaccination:
   - 2 ml syringe for solving BCG
   - 5 ml syringe for solving measles
2) All auto disable syringes and sterilisable syringes that have been used are to be kept in a safe box. Boxes containing auto disable syringes are to be given to health workers. The health workers should not recap syringes to avoid risks that may arise from the recapping of already used syringes
3) How to dispose of safe boxes: if an incinerator is available in a health institution, the health workers have to burn the safe boxes containing the used syringes in the incinerator. If the incinerator is not available, they should burn the used syringes in a hole at an appropriate place. The remains of the boxes after burning should be buried in a hole. Only after doing this, the in-charge of the concerned health institution shall certify that the safe boxes have been safely burnt and buried.

Review

- This policy was developed about 20 years ago.
- Although it is named as a 'policy', the majority of policy characteristics are lacking and on the cover page its validity is mentioned only for one year.
- This policy is more of a SOP dealing with use of vaccines and syringes for vaccination.
- It is very much service specific and so health system "building blocks" are not included.
- The policy essentially focuses on the quality aspect of vaccination services.
- The policy emphasises the quality of vaccination service provision at the point of service delivery.
- All vaccinations are given by auto disable syringes and the use of safety boxes for immunisation sessions is made mandatory. Similarly, guidelines on disposing of the safety boxes have been implemented.
- It can be replaced by a SOP to be developed by a federal ministry in the federal context.
- The Immunisation Act 2016, makes necessary arrangements for providing quality immunisation services and the development, expansion, and strengthening of immunisation services in the country with a view to prevention, control, elimination, and eradication of vaccine preventable diseases and thereby to reduce infant, child, maternal and other adults' mortality rate.

A1.18 National Drug Policy, 1995

The first policy on medicine was developed in 1995 and was named the "National Drug Policy". The policy was revised in 2001 which was decided at the Ministry level. The National Drug Policy 1995 was developed to complement the NHP, 1991. Although a draft of the new national medicine policy was prepared in 2007 and more recently in 2017, they were not endorsed by the government and hence the 1995 policy (with a revision in 2001) is still exists.

Objectives

1. To evolve a suitable mechanism to ensure access to essential and other medicines at a reasonable price throughout the country
2. To adopt a well-defined and effective mechanism for procurement, transportation, sale-distribution, storage, and dispensing of drugs at various levels of governmental and non-governmental health institutions
3. To supply an adequate quantity of essential drugs at each level of government health institution
4. To include drug industries as a priority sector by all concerned ministries of the GoN in order to make the nation self-reliant for the production of essential drugs
5. To develop pharmacy manpower for the effective implementation of the drug policy
6. To promote rational use of drugs and to establish a drug information system
7. To set up a well-equipped quality control laboratory with trained staff under the MoHP to carry out the testing, analysis, and standardisation of drugs
8. To develop an appropriate system to administer and monitor uniformity in drug prices
9. To define, promote, and regulate the quality and standards of Ayurvedic, Homeopathic, Traditional, and other systems of medicine by adopting a scientific approach
10. To improve the existing infrastructure of the Department of Drug Administration (DDA) and provide sufficient qualified and trained personnel for strengthening the drug administration mechanism and effective enforcement of the Drug Act
11. To consolidate and amend the existing Drugs Act, rules, and regulations to facilitate effective implementation of the Drug Policy

Under the heading of Policy Strategies there are six major areas of policy and the strategy statements are included in each of the policy themes.

Number of policy statements: 44 (as policy strategies)

Statements
Selection of Essential Drugs
1. The policy aims at preparing a National List of Essential Drugs in accordance with the World Health Organization's (WHO's) concept of essential drugs.
Procurement, storage, and distribution
2. The policy aims at procuring necessary drugs by accepting tenders from a list of standard manufacturers or their authorised agents and identified by the GoN using a pre-qualifying process.
3. The procurement of essential drugs will be made under generic names.
4. Drug related activities such as procurement, distribution, storage, and dispensing at government as well as non-government institutions will be carried out by qualified pharmacy personnel.
5. In order to ensure sufficient volume of the required drugs at different health institutions, the schemes related to partial or full cost-sharing will be implemented phase-wise.
6. Scientific methods must be applied for maintaining quality and minimising all possible changes in or deterioration of drugs during transport and storage.
7. The mechanism of procurement and distribution of drug will be modernised to assure timely supply of drug to all health institutions.
8. The regional offices of the DDA will be established phase-wise in all five regions of the country.
Quality assurance and regulatory control measures
9. The National Medicine laboratory will be developed as an independent National Quality Control Laboratory and under this organisational structure Regional Drug Testing Laboratory will be set up in a phase wise manner.

Statements
10. Drug registration will be based on scientific facts. The manufactures, import, sale, and distribution of ineffective, harmful, toxic, and irrationally combined formulations will be banned. 11. The submission of a certificate of "Good Manufacturing Practices (GMP)" issued as per WHO guidelines will be made compulsory for the registration of manufacturers of imported drugs. 12. The quality and standards of locally manufactured drugs will meet the standards of prescribed in National Code of Drug Manufacturing Conduct similar to WHO specifications. 13. The mechanism of registration and evaluation of drugs will be updated to ensure the quality of marketed products. 14. A definite customs point will be identified for the entrance of imported pharmaceuticals in the country. **Education and Training** 15. The health workers at all levels who are eligible to prescribe drugs, available at the health institutions, will be trained regularly on the "Standard Drug Treatment Schedule". The prescribers will have to adhere to the schedule allocated for the level of health care they are involved in. 16. Rational use of drugs will be promoted by involving the qualified pharmacists in the pharmacy services at all levels hospital services and other relevant institutions. 17. Curricula for training on different aspects of drugs will be developed and training will be conducted for pharmacists and other health personnel. 18. Training modules on production technologies, quality assurance, and good manufacturing practices will be developed for pharmacists involved in the production of drugs. **Drug information** 19. The GoN will effectively develop an efficient "Drug Information System" to disseminate the relevant information about proper use of drug, adverse reactions, pharmacology, toxicity, standards, and efficacy etc. to all concerned through different media including the publication of a National Drug Formulary. 20. Nepalese pharmacopoeia consisting of individual monographs, standards of drug materials, and accessory raw materials to be used in a formulation will be brought out. 21. Non-governmental organisations will also be encouraged to participate in providing information about the rational use of drugs to the public. **Prudent Use of Antibiotics (added by amendment in 2001)** 22. Prevailing antibiotics used in food products, animal feed, and agriculture substances will be managed properly. 23. Supervision and monitoring on the use of antibiotics will be carried out. Misuse will be controlled and a proper recording system will be developed. 24. Antibiotics will be classified into different groups for prescribing purposes by medical doctors, veterinary doctors, and other health personnel. 25. The GoN will create a national antibiotic control committee comprising of experts from human and animal health, agriculture, and representation from professional organisations/councils and organisations involved in consumer rights and other sectors for the prudent use of antibiotics. 26. The GoN will constitute a national antibiotics therapeutics advisory committee (NATAC) comprising of experts from relevant sectors to advice a prudent use of antibiotics. **Manpower Development** 27. A Pharmaceutical Affairs Unit will be set up in the MoH for the effective coordination of activities pertaining to pharmaceutical development. 28. Academic institutions will be encouraged to develop pharmaceutical education both in governmental as well as in non-governmental sectors for the production of qualified pharmacy

Statements
manpower required for the country. 29. Regulatory measures will be adopted to bring registration to pharmacy manpower involved in the various activities under the pharmaceutical profession. **National Drug Industry** 30. The domestic pharmaceutical industries will be accorded a status among national priority sectors. 31. The entrepreneurs will be encouraged to promote and establish pharmaceutical industries both in the public and private sectors. 32. The production of active ingredients, excipients, and packaging materials will be encouraged. 33. While purchasing drugs for the public sector, first priority will be given to domestic products in accordance with the financial regulations. 34. The GoN will provide facilities for importing machineries, equipment, raw materials, excipients, and packing materials required for the domestic pharmaceutical production. 35. The private sector will also be encouraged to set up quality control laboratories for drugs to be used within the country. **Traditional Medicines** 36. In order to promote drugs using Ayurvedic, Homeopathic, and other systems, the production of drugs for which the formula is well documented under their recognised literature will be facilitated both at governmental and private sectors. 37. The drugs based on these formulas as well as other ingredients will be modernised into dosage form and be subjected to scientific evaluation for their safety, efficacy, and quality. 38. Activities related to drugs under Ayurvedic, Homeopathic and other systems, will be developed suitably by involving qualified personnel and related technologies. 39. The Ayurvedic Department will conduct and coordinate all technical activities related to Ayurvedic drugs. **Research and Development** 40. Research on areas such as improved pharmaceutical technology for the production of bulk drugs as well as the development of the new drug delivery system will be encouraged. 41. Clinical trials of drugs will be carried out through the Nepal Health Research Council at institutions recognised by the GoN. **Technical Cooperation** 42. The GoN will encourage the involvement of national and international agencies for technical cooperation in areas of pharmaceutical manpower training and technology exchange. **M&E** 43. The GoN will create a committee responsible for the successful and effective implementation of the Drug Policy as well as for monitoring and supervision of its implementation. 44. The GoN will identify responsible sector for successful implementation of the national Drug Policy as well as develop criteria for its evaluation.

Review

- The policy does not cover medical products including health technology assessment.
- The policy does not address drug pricing.
- From a building blocks perspective, the policy's statements are less pronounced for the blocks of infrastructure.
- Essentially, the policy deals with the quality aspect of medicines and system reform but does not address the topic from an equity perspective.

- Based on the policy, the list of essential drugs has been revised three times, the WHO verified that GMP has become the basis of the registration of the drugs, the development of the Nepalese National Formulary (1997), the development of pharmacy human resources (domestic Bachelors in Pharmacy and Masters in Pharmacy courses are being offered), the expansion of drug manufacturing companies (currently 53 companies are producing allopathic medicines licensed by the DDA), and some institutional strengthening activities have been carried out.
- GMP is being practiced in most of the national pharma industry. For public purchase, it has been made mandatory to purchase only medicine certified as having GMP.
- Ayurvedic drugs are being tested for bacterial contamination.
- Since the allocation of the budget for the Department of Drugs is too low (it has remained less than 0.40 per cent of the MoHP budget for last three years), it is obvious that many of the activities based on the policy could not be implemented.
- Legal provision in the form of acts will be more powerful than this policy to ensure the quality and use of medicines. Other mechanisms can be dealt with by standards or SOPs.
- In essence, the policy is a sub-sectoral policy dealing with medicine.
- This policy envisioned the establishment of regional offices of the DDA in each of the five regions in a phase-wise manner.
- In the changed federal context and the functional assignment, the policy needs to be reviewed.

A1.19 Policy on Multi-dose Vaccine Vials for National Immunisation, 2000- 2001

This policy, developed in 2001, deals with use of multi-dose vaccines in the national immunisation programme. It focuses on saving opened vaccine vials, the disposal of opened vaccine vials, the management of stocks of vaccines, freeze dried and liquid vaccines with preservatives, the rate of wastage of vaccines, and adverse effects of vaccines. The scope of the policy is to guide the provision of safe immunisation services to the population.

Objectives

The policy does not define objective as such.

Number of policy statements: 1

Statements
Use of opened multi-vaccine vials: • Topic: Saving opened vaccine vials, the disposal of opened vaccine vials, management of stock of vaccines, freeze dried and liquid vaccines with preservatives, the rate of wastage of vaccines, and the adverse effects of vaccines

Review

- This policy was developed about 18 years ago and many developments have been made in this area since then.
- Although it is called a ‘policy’, it is more of a SOP dealing with the repeated use of vaccines. It deals with vaccination safety.
- The policy is very much service specific and so, health system building blocks are not defined.

- The policy essentially focuses on the quality aspect of vaccination services.
- From the perspectives of NHSS strategic directions, the policy emphasises on the quality aspect at the point of service delivery.
- As per the policy provisions, effective vaccine management (EVM) is being practiced throughout the country and surveillance of adverse effects following immunisation is being carried out.
- The policy is essentially focused on local functions from a federalism perspective.
- The Immunisation Act 2016 makes the necessary arrangements for providing quality immunisation services and so it can be a part of the Act and as such can guide as a SOP.

A1.20 National Safe Motherhood Policy, 1998

In 1998, the MoH published the Safe Motherhood Policy which included safe motherhood in the integrated reproductive health care package. This re-iterated the content of the Safe Motherhood Plan of Action 1994-97 and also gives high priority to improving the maternal and neonatal health status of the nation.

The Nepal Maternal Mortality and Morbidity Study done in 1998 highlighted the magnitude of the problem of the causes of maternal mortality in the country informed the policy. Therefore, this policy was developed to give priority to the Safe Motherhood Programme in an endeavour to reduce maternal deaths and disabilities. The overall scope of the policy is to guide the health services for safe motherhood as a major component of reproductive health.

General Objective

To reduce mortality and morbidity among women during pregnancy, childbirth, and the postnatal period through the adoption of a combination of health and health related measures.

Specific Objectives

- To increase the accessibility, availability, and utilisation of maternal health care facilities
- To strengthen the technical capacity of maternal health care providers at all levels of the health care system
- To strengthen referral services for maternity care, particularly at the district level and with specific emphasis on appropriate referral of high-risk cases
- To increase the availability and use of contraceptives for child spacing and family planning purposes
- To raise public awareness about the importance of the health care of women, particularly maternal health care and safe motherhood
- To improve the legal and socio-economic status of women

No. of Policy statements: 3

Statements
1) The MoH's Safe Motherhood Programme will be the HMG's main method to reduce maternal and neonatal mortality in Nepal.
2) The programme's main focus will be on the improvement of maternity care services, including family planning, at all levels of the health care delivery system and in the community.
3) In conjunction with the MoHP's programme, efforts will also be made to improve the general

status of women by promoting programmes aimed at bringing about attitudinal, behavioural, and societal changes regarding women's health concerns.

A total of 12 targets are also set in the policy, most of them are targeted for the year 2000. A number of strategies are followed by the policy statements.

Review

- The policy was developed about 20 years ago and the situation has been changed significantly since then including the leading causes of maternal mortality.
- The statements in the goals, objectives, and strategies sections are not consistently linked.
- There are only a few general policy statements considering the scope of the Safe Motherhood Programme which has widened in the present context e.g., disabilities, depression, fistula, and linkages with life course events such as adolescent, elderly etc.
- Within the Safe Motherhood Programme, the policy deals mainly with governance, human resources, drugs, and equipment and physical infrastructure up to district level while remaining silent on the topics of financing and information management.
- Achievements in maternal health have been good and Nepal achieved the MDGs in 2015.
- A significant amount of funding has been allocated to the Safe Motherhood Programme over the years.
- The policy statements do not address equity aspects which is one of the critical aspects in the current context.
- Although the policy also contains a number of strategies, a separate safe motherhood strategy was also developed in the same year, 1998, and it also includes a detailed work plan with various indicators to measure progress. However, these two sets of strategies, although developed in the same year, differ to some extent.
- This policy is more like a sub-sectoral policy dealing exclusively a specific programme component with focus on service delivery.
- The policy needs to be revisited in the federal context in accordance to the functions of the three levels of government.
- Recently, the constitution has included safe motherhood and reproductive health as the fundamental rights of women.

A1.21 National Policy on Mental Health, 1997

To materialise Nepal's commitment to the Alma Ata Declaration, the national policy on mental health was approved in 1997. The main thrust of the policy is to provide universal access to mental health services, enact legal measures to protect human rights of people with mental health problems, and to avoid stigma about mental health among the general populace. Although a draft of the revised mental health policy was prepared in 2007, it was not endorsed and hence remained as a draft. Furthermore, recently in 2017, the MoHP drafted a new version of the mental health policy which is yet to be endorsed by the cabinet and hence the official policy on mental health is still that of 1997.

Objectives

Although the policy does not define goals and objectives as such, the overall thrust of the policy is to expand mental health services for the protection of human rights along with provisions for competent human resources.

Number of Policy statements: 4

Statements
1) To ensure the availability and accessibility of minimum mental health services for the population of Nepal by the year 2000: in particular for the most vulnerable and under-privileged groups of the population, by integrating mental health services into the general health service system of the country, and by adopting other appropriate measures suitable to the community and the people
2) To prepare human resources in the area of mental health in order to provide for the above mentioned mental health services. This will include mental health training of all health workers, the preparation of specialist mental health manpower, and training of groups as needed
3) To protect the fundamental human rights of the mentally ill in Nepal
4) To improve awareness about mental health, mental disorders, and the promotion of mentally healthy lifestyles in the community through the participation of community structures and amongst health workers.

Review

- The document is a stand-alone policy which is developed in isolation from other health services.
- The policy does not address disability and rehabilitation as well as the issues of suicide and gender-based violence.
- The policy focuses on service delivery however it does not address the infrastructure, pharmaceuticals, and financing components of the health system.
- It covers quality, equity, system reform, and multi-sectoral collaborations which are the strategic directions of the NHSS.
- A number of achievements have been made in the field of mental health after the adoption of the mental health policy, however, ensuring the rights of affected people through legal measures still remains to be done.
- Mental health has been included as a component of essential health services and the supply of essential medicines has been made free.
- Preventive and promotive components of mental health now come under the responsibility of the Primary Health Care Revitalisation Division (PHCRD).
- A draft mental health (treatment and protection) Act was developed in 2006, however it has not been enacted yet.
- Similarly, some progress has been made towards integrating mental health services with the primary health system in a few districts, however, it remains to be a part of the nation-wide health system.
- The policy needs to be revisited keeping in view the federal structure and the services offered at health facilities.
- This policy was developed long back in 1995 and its revision is yet to be endorsed despite development of its revised draft in 2007 and 2017. This indicates that priority for mental health is given at policy level while commitment is lacking at the political level.
- However, in the current context, operational procedures may serve the purpose of the mental health policy as its intention is to improve access to mental health services.

A1.22 National Ayurveda Health Policy, 1996

The policy, developed in 1996, mentions that Ayurveda is a national method of therapy/treatment of Nepal. It gives the example that, like the heritage of the Himalayas and water resources, the original practices, manuscripts, records of Ayurvedic treatment, and medicinal use of abundant herbs have played an important role in the health system of Nepal. With this backdrop, this policy was developed in 1996 to effectively implement the commitment of the GoN towards Ayurvedic treatment.

Objective

To improve health conditions of the people and make them self-reliant on health treatment by officially and maximising the utilisation of local medical herbs and medical entities which are easily available and can be used persistently.

Number of Policy Statements: 32

Statements
Forms of Ayurvedic Treatment Services:
1) Ayurvedic treatment shall be developed as a special treatment method in the country in a phase-wise manner.
2) The organisation of the Department of Ayurveda will be reformed as required and various sections will be operated and consolidated.
3) The Ayurvedic hospital Nardevi will be upgraded to 100 beds and operated under a development board.
4) Autonomy will be granted to Singhdurbar Vaidyakhana and the preparation/formation and supply of Ayurvedic medicines will be well-managed and made effective by producing qualitative medicines of international standards and promoting exports.
5) The Ayurvedic Hospital in Dang will be converted into a Mid-Western Regional Ayurvedic Hospital.
6) In the four development regions, regional hospitals with 15 beds and a laboratory for medicine formation in each hospital will be established and operated.
7) The system of supervision, M&E, and the referring process of the technical and administrative functions of Ayurvedic hospital will be made effective.
8) Ayurvedic dispensaries will be equipped and made capable of producing, protecting, and promoting herbs available at the local level.
9) The building of Ayurvedic health centres and dispensaries will be carried out and the development of model herb farms will be developed in the premises thereof.
Inter-institutional and public participation
10) Health workers, wizards, women volunteers, birth attendants, and workers of social organisations in rural areas will be provided with trainings of growth, promotion, collection, and protection and use of herbs.
11) Inter-institutional coordination committees shall be set up and maintained at the governmental as well as non-governmental level, from national to rural level in the field of herbs, forest, conservation areas, environment, remote area development committee, agriculture, education sector etc.
Herbs farming, production, and enterprise of medicines
12) The qualitative business of herbs will be encouraged by developing model herbs farms.

13) Coordination will be made with governmental and non-governmental associations related to herbals.
14) Governmental and non-governmental Ayurvedic medicine manufacturing companies established or to be established in the country shall be encouraged to manufacture qualitative medicines on the basis of the 'Better Medicine Formation Code' and imports shall be reduced and export promoted. For this purpose, coordination shall be made with the Department of Drug Administration as well as with related governmental bodies.
15) One Ayurvedic Medicine Examination Committee and Laboratory will be developed for maintaining the quality of Ayurvedic medicine to be imported from abroad or prepared in the country as well as for other technical works.
16) Nepal Ayurveda Pharmacopeia will be collected and published in a timely manner.

Ayurvedic education and manpower development

17) A National Ayurvedic Institute, equipped with necessary equipment as well as a research centre, shall be established under Tribhuvan University, for enhancing and carrying on further development in the effective production of Ayurvedic human resources carrying out functions being dedicated to the field of Ayurveda and in standard of quality of its various dimensions (education, health, and preparation of medicines).
18) A programme for producing bachelor-level manpower in Ayurveda will be conducted.
19) The production of high level manpower will be continuously operated without confining such manpower to the number required for GoN (the then HMG/N)
20) Middle level and basic level Ayurvedic manpower will be produced and educational programmes will be launched for that purpose.
21) Naïve and foreign citizens who wish to gain introductory knowledge on Ayurvedic medicines will be provided with an opportunity to study.
22) Arrangements will be made for study and training programmes for manpower that cannot be produced within the country in foreign countries as necessary.
23) Arrangements will be made for in-service refresher trainings and study tours.

Management of Ayurvedic Manpower

24) Various organisational structures under the Ayurveda Group will be made responsive and service-oriented, for the consolidation of management aspect of Ayurvedic manpower.
25) Ayurvedic doctors and Ayurvedic health workers will be provided with the same allowances and special facilities as doctors or health workers of other systems.

Ayurvedic Research

26) An Ayurvedic Research Institute will be established furnished with the required equipment for research at international standards in matters related to the use of Ayurvedic medicines and entities and Ayurvedic treatment.
27) The Ayurvedic manuscripts available in the country will be preserved in a data bank, a reference library will be established, and timeliness reference materials will be published.
28) Magazines pertaining to the protection, framing promotion, utility methods, and environmental education of the herbs available in the country will be published, and national records thereof, prepared.
29) A campaign will be launched to protect and keep relevant the knowledge of traditional health workers.
30) Coordination will be maintained with the Ayurvedic Research Institute, National Ayurvedic Institute, Ayurvedic Hospitals, Governmental and Non-governmental Ayurvedic Medicine companies, and other related research institutes.

Provision of Resource Mobilisation:

31) Assistance of native and foreign donor agencies shall be made available so as to provide financial support to various programmes of Ayurveda, to mobilise the acquired financial resources by promoting the export of herbs and prepared medicines, and to assist in the implementation of the said programme.

Nepal Ayurvedic Medicine Council

32) A Nepal Ayurvedic Medical Council will be established at the national level for fixing necessary standards of Ayurvedic education and services, the registration of doctors, and well-arrangement and M&E of their jurisdiction.

Review

- The policy is not in the usual format of a GoN policy.
- The policy was developed more than 20 years ago and needs updating.
- The policy addresses all the components of building blocks except infrastructure and equipment.
- From the view of NHSS strategic directions, it focuses more on the quality aspect of services, but does not adequately address equity aspects.
- Most of the statements are equivocal from the point of view of the current federal structure.
- A revision of the policy has been planned in the annual workplan and budget (AWPB) in FY 2016/17 considering the federal context.
- Commitments and provisions of World Trade Organisation (WTO) in relation to traditional medicines are not addressed at all.
- The institutional structures as proposed in the policy are not set up yet.
- The implementation status of the policy could not be ascertained properly because no implementation plan was prepared.
- The policy does not address the listing and documentation of medicinal herbs that are available in Nepal.
- The existing dual responsibility about the medicinal herbs (Ministry of Forest vs. the MoH) is not addressed through this policy.
- In light of mention of Ayurvedic services in the Constitution, its placement and scope needs reconsideration as a policy.
- From the service provision perspective, a “one door” approach should be promoted at the local level.
- The policy has the provision of research, however, one of the major problems with Ayurveda in Nepal is the scarcity of scientific evidence of its treatment. There has been no significant progress on this. However, with the establishment of Ayurved Training and Research Centre in Kathmandu, it is expected that this gap will be filled in future.

Annex 2: Qualifiers for policy mapping by health systems building blocks

Governance: legal arrangement, rules, regulation, monitoring, evaluation, supervision, governance, planning, strengthening, collaboration, coordination, organisation, institution, system, regulation, management, Rights, practice, establish, Committee, develop, strengthen, priority, quality, prevent, avoid, implication, ensure, standard

Physical infrastructure and equipment: infrastructure, equipment, building, maintenance, strengthen, safety, technology

Services delivery: service, integration, promote, access, health, medicines, supply, surveillance, follow up, referral, implement, increase, coverage, reduce, control, diagnosis, sustain, identify, provide, improve, utilise, method

Pharmaceutical and laboratories: pharmacy, laboratory, testing, procurement, medicine

Human resources: training, job, academy, capacity development, education, personnel

Health financing: allocation, budget, fund, capacity, pool, collect, payment, expenses

Information and research: information, research, data, reporting, dissemination, media, communication, message, survey

Annex 3: Qualifiers for policy mapping by NHSS strategic directions

Quality: standards, specialty, better, safety, regulation, integration, safe, secure, quality, capacity, correctness, Proper use, special practice, choice, reference, protocol

Equity: promotion, priority, justice, poor, marginalised, Policy, law, disadvantage, appropriate, gender, disabled, senior citizen, inclusion, targeting, expenditure, coverage, access

Reform: effective, efficiency, relationship, reinforce, capacity, priority, establish, govern, mainstreaming, entitle, procedure, Act, law, research, correct, participation, governance, sustaining, intervention, increase, decrease, output

Multi-sectoral: collaboration, coordination, partnership, assistance, mobilisation, resources, participation, cooperation, technology transfer,

Annex 4: Qualifiers for policy mapping by three levels of government

Federal: actions that need to be planned, implemented and directed by the government at highest level as defined in the unbundling of services

Provincial: actions that are under the provision of the provincial government (in the past, regional offices)

Local: actions that need to be carried out by local government, remote, local, community, Village Development Committees

Equivocal: actions that are carried out by all three tiers of government or as mentions in the list of concurrent actions by federal, provincial or local governments, all level, GON, NGO, private organisations