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Review of National Health Policy 1991

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Strengthening Health Systems-Improving Services

EXECUTIVE SUMMARY

Chapter 1. INTRODUCTION

National Health Policy, 1991 — In 1991 Nepal's government introduced a National Health Policy. Its core objective was to upgrade the health standards of the majority of the rural population by extending basic primary health services and making modern medical facilities available at the village level. It called for prioritising preventive, promotive and curative health services to reduce infant and child mortality. The policy has 15 components ranging from preventive health services to blood transfusion services and miscellaneous issues. This policy is now more than 20 years old, is out-of-date and needs revising.

Policy review — In December 2011–January 2012 a review of the National Health Policy, 1991 was carried out to assess progress under the 1991 policy and to identify issues and options to consider in a new health policy. This exercise proceeded by reviewing the 1991 policy and the many new sub-sector health policies and by meeting and discussing health policy needs with central level stakeholders from the government, international development agencies, academia and the private sector.

Chapter 2. REVIEW OF NATIONAL HEALTH POLICY, 1991

This review reports the following progress against the 1991 policy:

1. Preventive health services — Integrated service delivery at the sub-health post level and up to district level is making a large contribution to reducing infant and child mortality and other health improvements.

2. Promotive health services — A National Health Education, Information and Communication Centre was established in 1992, but there has been only limited impact on improved behaviour for health; there has been a lack of coordination with other sectoral ministries for promoting nutrition programmes and environmental health programmes have not gone ahead to the required extent.

3. Curative health services — The target of one hospital per district has been achieved but the target of establishing zonal and regional hospitals with higher level health services has not been fully achieved, while central hospitals lack essential specialist equipment and referral systems have not been adequately developed.

4. Basic primary health services — Sub-health posts have been established in all village development committees (VDC) and primary health care centres in all constituencies. Sub-district level health facilities are being upgraded. However, the commitment made to expand hospitals on the basis of population and patient loads has not been followed. The removal of user charges has led to the increased uptake of basic health services and drugs.

5. Community participation in health services — Community involvement at all levels has been encouraging with more than 50,000 female community health volunteers and VDCs donating space to run sub-health posts.

6. Organisational and management reform — District hospitals and public health offices have been integrated under single administrations; health facilities are displaying the services they offer to the public and there have been large improvements in transporting drugs and equipment to districts. However, there is inadequate use of data generated by the Health Management Information System.

7. Development and management of human resources for health — Many new public and private institutes have been established and/or new courses set up since 1991 to train human resources for health and Nepal is now mostly producing the human resources for health it needs. The main issues concerning the training and retention of human resources for health are:

- the weak regulatory mechanisms governing public and private health facilities and the lack of production of certain types of health personnel including physiotherapists and health educators;

- the challenge of retaining doctors and other health personnel in rural and remote postings and challenges related to the transfer, upgrading and career development of health personnel; and
- insufficient staffing of the National Health Training Centre for in-service training.

8. Private, NGO and inter-sectoral coordination — There has been a large growth in the number of private hospitals and other health facilities since the early 1990s. However, almost all are located in urban areas and focus on curative services; the minimum standard guidelines for private health facilities have not been fully implemented and there is a lack of coordination between the health and the agriculture, education, drinking water, local development and other health-related sectoral ministries.

9. Ayurveda and traditional health systems — Such systems have not been developed to the required extent and research based practice is yet to take place.

10. Drug supplies — The new National Drug Policy, 1995, successfully encouraged greatly increased domestic drug production. However, adequate logistics systems are still lacking for supplying medicine and health equipment to health facilities.

11. Resource mobilisation — The proportion of the national budget dedicated to the health sector has increased since 1991 and large amounts of aid provided by external development partners. A sector-wide approach (SWAp) for coherent and sustainable financing for health is being implemented. The removal of user fees for basic health care has led to more use of health facilities to put more pressure on budgets.

12. Health research — Although the Nepal Health Research Council was established in 1991, scant policy research has been carried out and research findings are not adequately used for decision making.

13. Regionalisation and decentralisation — Regional laboratories, a health training institute, medical stores and other health facilities have only been established in some regions. The government has began to introduce the decentralised management of health facilities, but this has been hampered by the continuing lack of elected local representatives.

14. Blood transfusion — The Nepal Record Cross Society became solely responsible for the country's blood transfusion service in 1993.

15. Miscellaneous issues — Programmes for the welfare of disabled persons have been implemented and progress made against smoking and other harmful practices. There has been little progress on health and safety for workers.

Chapter 3. NEW HEALTH RELATED POLICIES, STRATEGIES AND PLANS

In the 20 years following the introduction of the National Health Policy, 1991 a total of 15 new sub-sector health policies, four health strategies and three overall plans have been introduced and implemented for the health sector. Many of the issues covered in these documents are detailed reckonings of issues not included in the National Health Policy, 1991 and thus need considering in the new health policy. The Interim Constitution, 2007 guaranteed access to basic health care as a fundamental right

Chapter 4. CHANGES IN HEALTH INDICATORS AND DETERMINANTS OF HEALTH

The twenty years since the introduction of the National Health Policy, 1991 has seen a very large increase in the number of health facilities, substantial improvements in health indicators, reduced levels of population growth and other changes in Nepali society that determine the health of the population.

Chapter 5. STAKEHOLDER PERCEPTIONS ON ISSUES FOR INCLUSION IN NEW HEALTH POLICY

As a part of this review a range of central level health stakeholders identified the issues to be considered by the new health policy. They recommended that a new policy should only be formulated after the new federal constitution is promulgated. They identified the gaps in the 1991 policy as being its rural-only focus, its lack of attention to the special needs of women, children, poor and excluded people; its lack of attention to inter-sectoral issues and that it did not give specific policies on social security and health protection issues. The many specific observations in this Chapter 5 are mostly covered in Chapter 6 as issues for consideration in the new health policy.

Chapter 6. ISSUES FOR THE NEW HEALTH POLICY TO ADDRESS

This review identified a range of issues for consideration in the new national health policy including the following overall issues:

- reach all citizens with health services (the 1991 policy focused on reaching rural people);
- take proactive measures to reach disadvantaged groups with health services;
- ensure the geographic accessibility of health services, particularly in mountain areas;
- provide quality health services (the 1991 policy focused more on quantity of services).

Access to health services — The review gives 24 specific recommendations for improving access to health services under the following headings:

- increase access to and use of health services;
- improve the provision of essential health care services;
- health services beyond essential health care —non-communicable diseases;
- strengthen and expand health facilities and services; and
- improve the quality of health services.

Strengthening the health system — The review gives 32 specific recommendations for strengthening the functioning of Nepal's health system under the following headings:

- human resources for health;
- ayurveda and other traditional systems of medicine;
- engaging the private and NGO sectors;
- resource mobilisation;
- organisational reform; and
- miscellaneous issues.

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1 INTRODUCTION

National Health Policy, 1991 — The pro-democratic people's movement of 1990 re-established a constitutional monarchy and multi-party democracy in Nepal. Soon after, in 1991, the government developed a National Health Policy (NHP 1991) (see Annex 2 for full version) with the following vision, objectives, approaches and components:

- **Vision** — The government committed to creating a socio-economic environment to allow all Nepalese citizens to lead a healthy life.
- **Objective** — The policy called for upgrading the health standards of the majority of the rural population by extending basic primary health services and making modern medical facilities available at the village level for rural people.
- **Approaches** — The highest priority was given to upgrading the health standard of people living in rural areas using a primary health care approach (in line with the Alma Ata declaration, 1978 for primary health care to which Nepal was a signatory). Priority was given to preventive, promotive and curative health services to reduce infant and child mortality.
- **Fifteen components** — The policy has the following 15 components or areas, which are given in full in Annex 2 and summarised in Chapter 2:
  1 Preventive health services
  2 Promotive health services
  3 Curative health services
  4 Basic primary health services
  5 Community participation in health services
  6 Organisational and management reforms
  7 Development and management of human resources for health
  8 Private, non-government health services and inter-sectoral coordination
  9 Ayurvedic and other traditional health services
  10 Drug supply
  11 Resource mobilisation in health services
  12 Health research.
  13 Regionalisation and decentralisation
  14 Blood transfusion services
  15 Miscellaneous.

Health situation in 1991 — The policy says that the health situation of the country was poor due to a lack of political commitment, inappropriate strategies and the weak implementation of health programmes. The policy illustrates the generally poor health and inadequate numbers of health personnel and facilities with the figures in Tables 1 and 2 below. Table 1 also shows the targets of the 1991 policy.

Need for updating policy — Many new policies, strategies and plans and other developments have been introduced since 1991, most of them addressing points in the National Health Policy, 1991 (see Chapter 3). These and other developments mean that the National Health Policy, 1991 is out of date and in need of revision. The current review is being carried out to identify issues and options to consider in a new health policy.

Table 1: Health situation and targets in NHP 1991

Indicator	Situation in 1991	Target for year 2000 (NHP 1991)
Infant mortality rate	107 per 1,000 live births	50
Under-five mortality rate	197 per 1,000 live births	70
Maternal mortality ratio	850 per 100,000 live births	400
Fertility rate (children per women aged 15-49 years)	5.8 children	4 children
Life expectancy	53 years	65 years

Table 2: Health facilities in rural Nepal as per NHP 1991

Indicator	Situation in 1991
Rural population to hospital ratio	168,000 people
Rural population to a hospital bed ratio	4,000 persons
Rural population to health post ratio	24,000 persons
Rural population to doctor ratio	92,000 persons

Policy review — A desk review of the National Health Policy, 1991, and key health policies, strategies and plans introduced after 1991 was carried out in December 2011 and January 2012. To substantiate the findings of this review, consultation and interviews were held with officials and representatives from the Ministry of Health and Population (MoHP), Department of Health Services (DoHS), Department of Drugs Administration (DDA), the National Planning Commission, international development agencies, academia, the private sector and international NGOs (INGOs). See Annex 1 for list of people interviewed and met with in the course of this review. A dissemination workshop was held on 30 July 2012 in which many valuable inputs and suggestions were collected. These suggestions were incorporated in the recommendations.

2 REVIEW OF NATIONAL HEALTH POLICY, 1991

This chapter explains the progress made on implementing the National Health Policy, 1991 up to the end of 2011.

1. Preventive health services

Situation in 1991 — Preventive health services, which had previously come under vertical programmes such as immunisation and family planning, were brought under the direct control of the Ministry of Health in 1987. This reorganisation abolished the Department of Health Services. Five regional health directorates and 75 district public health offices were established under the Ministry of Health. Higher level (secondary and tertiary) health services were provided by central, regional, zonal and district hospitals under the ministry's Curative Division. Primary health care was delivered by health posts and health centres, which were managed by district public health offices.

NHP 1991 policies:

- To prioritise programmes that directly help reduce infant and child mortality rates
- To provide services in an integrated manner (not as vertical programmes) through sub-health posts at the rural level.
- To run 11 types of preventative health programmes ranging from family planning and maternal and child health to HIV prevention (see Annex 2 for full list).

Achievements — Integrated service delivery has happened at sub-health post level and up to the district level. In general this integrated service delivery has worked well although in many cases resources have been insufficient and staff inadequately trained. This has successfully reduced infant and child mortality such that Nepal is on course to achieve the infant and child mortality Millennium Development Goals by 2015 (see Table 9).

2. Promotive health services

NHP 1991 policy: Give priority to programmes that enable people to live healthy lives across the three subjects of:

- health education and information;
- nutrition; and
- environmental health.

Achievements:

- A National Health Education, Information and Communication Centre was established in 1992 to promote public awareness on health matters. However, the provision of health education from central to village level has not had the desired impact on changing behaviour.
- To promote good nutrition the Ministry of Health has lagged behind in coordinating with other ministries on this subject especially with the sectoral ministries for agriculture, education, water supply and local development.
- The environmental health programmes envisaged in the policy (on personal hygiene, solid waste management, food standards and other subjects) have not gone ahead to the required extent mainly due to a lack of coordination between concerned ministries.

3. Curative health services

NHP 1991 policies: On curative health services NHP 1991 called for nine actions including:

- making health services available in an integrated (not vertical) way in rural areas;
- organising mobile teams to provide specialist services to remote areas;
- establishing zonal and regional hospitals in all 13 zones and 5 regions to provide specialised services;
- equipping central hospitals with sophisticated diagnostic and other facilities;
- developing a referral system to direct the rural population to well-equipped institutions; and
- basing hospital expansion on population density and patient loads.

Achievements — The target of one hospital per district has been achieved and teams have been mobilised to remote places to provide specialist services to needy people.

However, the policy of establishing hospitals at different levels with defined services has not been fully achieved as zonal hospitals still lack speciality services and regional hospitals have not been established as planned with only two existing (Surkhet and Pokhara) against the five planned. The central hospitals (mostly in the Kathmandu Valley) mostly lack adequate sophisticated diagnostic and other facilities, while referral systems have not been developed as envisioned. Also, less progress has been made on establishing functioning diagnostic services (e.g. x-ray and laboratory testing services) in all hospitals.

4. Basic primary health services

NHP 1991 policies: Establish sub-health posts in all village development committees (VDC) and upgrade one health post in all 205 electoral constituencies in a gradual manner and convert them to primary health care centres.

The policy proposed the following health infrastructure and population ratio from central to peripheral levels (see Appendix 1 of Annex 2):

- One sub-health post in all 3,199 VDCs to cover an average of 4,000 people each.
- One health post in all 611 ilakas (= 5 adjoining VDCs) to cover an average of 29,000 people each.
- One primary health centre in all 205 electoral constituencies to cover an average of 100,000 people each.
- One district health office/district hospital in all 75 districts to cover average of 200,000 people each.
- One zonal hospital in all 14 zones to cover average of 1.3 million people each.
- One regional hospital in all 5 regions to cover average of 3.6 million people.
- Central hospitals providing super-specialist services and teaching facilities.

Achievements — The target of establishing new sub-health posts in all VDCs and primary health care centres in all electoral constituencies has been achieved to greatly improve access to basic health services. According to the Management Division, of the Department of Health Services in 2010 there were 4,000 public health facilities (207 primary health care centres and health centres, 1,176 health posts, and 2,617 sub-health posts). These facilities are being gradually upgraded to higher levels. Each year about 500 sub-health posts are being upgraded and primary health care centres are being upgraded to community or rural hospitals.

However, the commitment made to expand hospitals and other facilities on the basis of population and patient load has not been followed. The ratio of health facilities to administrative units has mostly been achieved but the ratio to number of people has not with, for example, inadequate facilities in urban areas.

The Free Essential Health Care Policy, 2008 has led to user charges and community drug programmes being replaced by the free provision of basic health services and drugs. This has led to an increased uptake of services.

5. Community participation in health services

NHP 1991 policies: Seek community participation at all levels of health care through the participation of female community health volunteers (FCHV), traditional birth attendants (TBA) and leaders of various local social organisations.

Achievements — Community involvement at all levels has been encouraging. More than 50,000 female community health volunteers are providing basic health services to communities. Also, most VDCs have donated space (usually in VDC buildings) to run sub-health posts.

6. Organisational and management reform

NHP 1991 policies: Improve the organisation and management of health facilities at central, regional and district levels. This includes integrating district hospitals and public health offices into district health offices, informing the public about which services are available, using health information to inform decision making and improving systems for supplying health facilities with drugs and equipment.

Achievements:

- In almost all districts, district hospitals and public health offices have been integrated under a single administration, although there are conflicts between medical and public health personnel.
- In line with the government's citizens' charter (2005), it is mandatory for health facilities to display the services they offer and their cost.
- Although a strong Health Management Information System (HMIS) exists, the data and information it generates is little used for decision making.
- Improvements in the health logistics management system and the expansion of the road network have led to improvements in transporting drugs and equipment to districts. But there are still significant problems.

See Box 1 for current organisational structure of the health ministry and higher level health facilities.

Box 1: Organisational structure of Nepal's health system, 2011

In 2005 the government shifted the population wing of the Ministry of Environment and Population to the Ministry of Health, which was renamed the Ministry of Health and Population (MoHP). The three departments of this ministry are the Department of Health Services, Department of Drug Administration and the Department of Ayurveda. The Department of Health Services has five centres and seven programme divisions.

As of 2011, Nepal's national health system is made up of 8 central hospitals, 5 regional health directorates, 2 regional hospitals, 1 sub-regional hospital, 5 regional training centres, 1 sub-regional training centre, 5 regional medical stores and a South Asia regional tuberculosis and HIV centre. There are also 10 zonal hospitals, 60 district health offices, 65 district hospitals and 15 district public health offices.

7. Development and management of human resources for health

Situation in 1991 — Tribhuvan University's Institute of Medicine (IoM) was the only institution training health personnel who work in below district level health facilities (mid and basic level health workers).

NHP 1991 policies:

- Develop technically competent human resources for all health facilities and strengthen training centres and academic institutions. Note that the policy only called for developing the Institute of Medicine for developing human resources for health.
- Reform the systems for staff transfer and promotion and career development.
- Provide special benefits for doctors and other health personnel to encourage them to work in remote rural areas.

Achievements — Many new public and private institutes have been established and/or new courses set up since 1991 to train human resources for health. This is reflected in the large number of students admitted to bachelor level and above courses (Table 3) and mid-level courses (Table 4) in academic year 2010/11.

Table 3: Intake on higher-level health training courses, 2010/2011

Course	Annual intake		
	Public institutes	Private institutes	Total
Postgraduate and above	287	48	335
Master of Public Health (MPH)	34	10	44
Bachelor of Medicine, Bachelor of Surgery (MBBS)	163	1,275	1,438
Bachelor of nursing and science (BN, BSc)	196	1,760	1,956
Bachelor of public health (BPH)	40	880	920
Other	28	20	48

Source: Websites, annual reports and admission notices of Institute of Medicine (IoM), BP Koirala Institute of Health Sciences (BPKIHS), National Academy of Medical Sciences (NAMS) and private medical colleges

Table 4: Intake on training courses for mid-level human resources, 2010/11

Types of post	No. of institutes	Estimated annual intake
Nursing	85	3,434
Health assistant	45	1,800
Medical laboratory technician	41	1,230
Assistant pharmacist	24	960
Radiographer	15	450
Ophthalmic assistant	1	40
Homeopathic assistant	1	40
Ayurveda (HA)	3	120
Dental assistant	5	200

Source: Council for Technical Education and Vocational Training (CTEVT)

Nepal is now therefore mostly producing the required human resources for health as envisioned in the policy. Many of the trained personnel have joined the government health service, which has seen a very large increase in health personnel since 1991 (see Table 3).

Table 5: Number of government health personnel 1991–2011

	1991	2011
No. government doctors	750[8]	1,798[12]
No. nurses	601[8]	18,346[10]
No. auxiliary nurse midwifes	2,062[8]	18,307[10]
No. paramedics (health assistant/auxiliary health workers)	1,017[8]	7,491[12]
No. maternal and child health workers	-	2,985[12]
No. health workers (PHWs and VHWs)	2,626[8]	3,190[9]
No. health volunteers/female community health volunteers	4,570[8]	48,489[11]

Sources: 7. Health Information Bulletin No 8, MoH, 1992; 8. Country Health Profile, MoH, 1988; 9. Management Division, DoHS, 2010; 10. Nepal Nursing Council Register, 2011; 11. Annual Report, DoHS, 2009; 12. Budget, Annual Plan and Progress Report of MoHP, 2012

There are several major issues concerning the training and retention of human resources for health:

- **Regulating institutes** — Most training institutes are guided by market forces, there is a weak regulatory mechanism and the right skill mix of human resources for health is not being produced. For example, not enough physiotherapists, environmental health technicians, health educators, health economists and other types of health personnel are being produced.
- **Remote postings** — Although there are now many trained doctors and nurses in Nepal it is still a challenge to get them to serve in remote parts of the country. The Health Service Act and regulations 1997/98 called for providing incentives and bonds to get health personnel (particularly doctors and nurses) to work in remote areas. Although efforts have been made to implement this it is difficult to motivate staff to work in remote postings due to the many attractions of working in urban areas and the lack of career development opportunities in remote postings.
- **Career management** — There are problems related to posting, transfer, career development, performance evaluation, supervision and incentives. The government has to follow the Health Act and Regulations regarding transfer, upgrading and career development.
- **NHTC —** The National Health Training Centre is an apex body of the Ministry of Health and Population for in-service training with training centres in each of Nepal's five regions. It provides in-service training to all levels of health personnel. However, it is yet to be adequately staffed with a multidisciplinary faculty.
- **Staff shortages** — The many new training centres and courses have attracted trained health professionals away from working in public health facilities causing shortages of skilled staff in government sector in certain disciplines.

8. Private, NGO and inter-sectoral coordination

NHP 1991 policies: The Ministry of Health will co-ordinate activities with the private sector, non-governmental organisations (NGOs) and government non-health sectors; and the private sector and NGOs will be encouraged to provide health services.

Achievements — There has been a large growth in the number of private hospitals and other health facilities since the early 1990s, almost all located in urban areas and focussing on curative services.

However:

- Although guidelines have been developed for minimum standards for private health facilities, they have not been fully implemented due to weak regulatory and monitoring mechanisms.

- The private sector is yet to provide services in rural areas, although this gap is being partly filled by NGOs.
- There continues to be a lack of coordination between the health and agriculture, education, drinking water, local development and other ministries.

9. Ayurveda and traditional health systems

Situation in 1991 – There were 1 ayurvedic hospital (Kathmandu), 14 zonal ayurveda clinics (aushadhalaya), 68 district ayurvedic health centres, one homeopathic hospital and one unani dispensary in Kathmandu.

NHP 1991 policies: Encourage the development of the ayurvedic system and other traditional health systems (such as unani, homeopathy, and naturopathy).

Achievements — Ayurveda is a system of traditional medicine native to India. A National Ayurvedic Health Policy was introduced in 1996. However, although deep rooted in Nepalese society, this system of medicine is not attracting the general public to the desired extent. Research based practice is yet to take place. Other systems of medicines such as Unani (a form of traditional medicine widely practiced in South Asia), homeopathy, naturopathy have not flourished. The Institute of Medicine began a bachelor level ayurveda course in 1996.

As of 2011 ayurvedic health services are being delivered through two ayurveda hospitals (a one 100 bed hospital in Kathmandu and a 30 bed hospital in Dang), 14 zonal ayurveda clinics, 61 district ayurvedic health centres and 214 ayurvedic centres. There is one Ayurvedic Medicine Manufacturing unit. A total of 1,524 posts are sanctioned within the Department of Ayurveda of which 791 posts are technical and 98 administrative. There is one homeopathic hospital and one unani dispensary in Kathmandu.

10. Drug supplies

NHP 1991 policies: Improve the supply of essential drugs by increasing domestic production and upgrading the quality of essential drugs by implementing the National Drug Policy.

Achievements — A new National Drug Policy was introduced in 1995, that has successfully encouraged domestic drug production. The domestic production of essential drugs, mostly by the private sector, has met the expectations of the policy. To some extent drugs produced in Nepal have replaced ones imported from India and other countries. NHP 1991 did not however adequately spell out the need for an overall logistics system including procurement, storage, quality and distribution of medicine, vaccines, contraceptives, equipments and other supplies.

11. Resource mobilisation

Situation in 1991 — As of 1991 the annual health sector budget accounted for less than 5% of the national budget.

NHP 1991 policies: Mobilise national and international resources and explore alternative concepts (such as health insurance, user charges, and revolving drug schemes).

Achievements — The proportion of the national budget dedicated to the health sector has increased to about 7%. The government has on several occasions committed to increasing the health budget to 10% of the total; but this has yet to happen.

Large amounts of aid for health has been provided by external development partners. Coordination and harmonisation in foreign aid has improved as has the national capacity for planning and managing financial matters. The Health Sector Reform Strategy, 2003 called for a sector-wide approach (SWAp) for coherent and sustainable financing, which is currently being implemented under the Nepal Health Sector Programmes 2 (2010 to 2015).

The Free Essential Health Care Policy, 2008 led to user charges and community drug programmes being replaced by the free provision of basic health services and drugs. This has led to more use of health facilities and their services, which has led to larger pressure on budgets. As a result, the sustainability of this new model is being questioned and there is a need to explore alternative funding modalities such as health insurance, reviving user charges, and revolving drug schemes.

12. Health research

NHP 1991 policies: To encourage health research for the better management of health services.

Achievements — The Nepal Health Research Council was established in 1991 to facilitate research in the health sector. However, scant policy research has been carried out and findings from surveys and routine information collection are not adequately used for decision making.

13. Regionalisation and decentralisation

NHP 1991 policies: Strengthen decentralisation and regionalisation and make peripheral units more autonomous. Give district health offices (DHO) a prominent role in planning and managing curative and promotive health services from district to village levels. The proposed organisational structure (see Annex 2) gives five types of regional level health facilities including regional hospitals.

Achievements — Regional laboratories, health training, medical stores and other health facilities have only been established in some regions. The Local Self Governance Act 1999, gave considerable responsibilities to local government bodies at the district municipality and VDC level for running health facilities. In line with this legislation the Ministry of Health has moved to decentralise health facilities by forming inclusive health facility operation and management committees. These committees have been made responsible for managing health facilities. The bottom-up planning of health programmes has been introduced involving district development committees and VDCs and micro-planning procedures have been adopted for extending preventive health services at the village level. The implementation of the Local Self-governance Act, 1999 is hampered by the continuing lack of elected representatives at district levels and below.

14. Blood transfusion

NHP 1991 policy: Authorise the Nepal Red Cross Society to conduct all programmes related to blood transfusion. Prohibit the practice of buying, selling and depositing blood.

Achievements — The Nepal Record Cross Society became responsible for the country's blood transfusion service and the practice of buying, selling and depositing of blood following the introduction of the National Blood Policy, 1993.

15. Miscellaneous issues

NHP 1991 policies: These issues were worker health and safety, law and regulatory reform, anti-smoking, anti-alcohol and substance abuse campaigns, and programmes for disabled persons.

Achievements — Programmes for the welfare of disabled persons have been implemented in coordination with the private and NGO sector and awareness programme have been run against smoking and other harmful practices. Nepal endorsed the international Framework Convention on Tobacco Control (FCTC) in 2006 and following this banned the advertising of tobacco products and alcohol on the electronic media and banned on smoking in public places. The least achievements have been made on health and safety for workers.

3 NEW HEALTH RELATED POLICIES, STRATEGIES AND PLANS

The introduction of the National Health Policy 1991 was followed by continuing the restructuring and reorientation of health services. The policy also led to the introduction of many new sub-sectoral health policies and strategies (see Table 6) that have gone a long way to implementing much of the National Health Policy, 1991. Many of the issues covered in these policies, strategies and plans were more detailed issues not included in the National Health Policy, 1991 and thus need considering in the new health policy.

Table 6: Health policies, strategies and plans and government periodic plans, 1991–2011

Policies	
1	National Blood Policy, 1993 (revised 2005)
2	National Drug Policy, 1995
3	National AIDS Policy, 1995 (updated 2011)
4	National Mental Health Policy, 1995
5	National Ayurveda Health Policy, 1996
6	National Safe Motherhood Policy, 1998
7	National Health Research Policy, 2003
8	National Oral Health Policy and Strategies, 2004
9	National Nutritional Policy and Strategies, 2004
10	National Safe Abortion Policy, 2006
11	National Skilled Birth Attendants (SBA) Policy, 2006
12	Health Care Technology Policy, 2006
13	Policy on Quality Health Services, 2007
14	Free Essential Health Care Policy, 2008
15	Free Delivery Policy, 2009
Strategies	
1	National Reproductive Health Strategy, 1998
2	National Adolescent Health and Development Strategy, 2000
3	Health Sector Strategy: An Agenda for Reform, 2003
4	National Neonatal Health Strategy, 2004
Health plans	
1	Second Long Term Health Plan, 1997–2017
2	Nepal Health Sector Programme, 2004–2010
3	Second Nepal Health Sector Programme, 2010-15
Government periodic plans	
1	Eighth Five Year Plan, 1992-191997
2	Ninth Five Year Plan, 1997–2002
3	Tenth Five Year Plan, 2002—2007
3	First Three Year Interim Plan, 2007/8–2009/10
4	Second Three Year Interim Plan, 2009/10–2011/12

3.1 Periodic plans and the interim constitution

Between 1991 and 2011 the government implemented five periodic plans and introduced a new constitution. The following summarise the main health related points from these documents.

1. Eighth Five Year Plan, 1992-97

The health part of the eighth five year plan called for attaining the highest level of health for all Nepalese people and spelled out the need to:

- improve the health of the people in order to provide healthy people for the country's development;
- extend basic and primary health services to rural areas to improve the health of rural people;
- extend family planning and maternal and child health services to the local level; and
- develop specialised health services accessible throughout the country.

2. Ninth Five Year Plan, 1997-2002

This plan emphasised:

- improving the health status of the people and supporting poverty eradication in this way;
- mobilising the private and non-government sectors for quality health services and human resource development;
- improving the cost-effectiveness of health service provision;
- developing policies to solve problems related to the environment of professional health care;
- promoting people's participation, inter-regional coordination and decentralisation; and
- exploring alternative means of health care financing.

3. Tenth Five Year Plan, 2002-07

The Tenth Plan, also known as Nepal's Poverty Reduction Strategy Paper, focused on poverty alleviation and called for:

- making essential health care services available to all;
- establishing a decentralised health system;
- establishing public-private-NGO partnerships to deliver health care services; and
- improving the quality of health care through total quality management of human, financial and physical resources.

4. The interim constitution, 2007

The interim constitution, 2007 guaranteed access to basic health care as a fundamental right thus:

- Article 16. 2 — Every citizen shall have the right to get basic health services free of cost from the State as provided for in the law.
- Article 20.2 — Every woman shall have the right to reproductive health and other reproductive matters.
- Article 22.2 — Every child shall have the right to get nurtured, basic health and social security.

5. First Three Year Interim Plan, 2007/8-2009/10

This plan established the right of citizens to free basic health care and said that preventive, promotive and curative health services shall be implemented as per primary health services. The plan focussed on:

- laying a foundation for economic and social transformation;
- adopting an inclusive development process and carrying out targeted programs while focusing on excluded groups; and
- establishing the right of all citizens to free basic health care services without any discrimination by region, class, gender, ethnicity, religion, political belief or social and economic status, keeping in view the broader context of social inclusion.

6. Second Three Year Interim Plan, 2009/10-11/12

The second interim plan also calls for quality health care services for all by:

- encouraging partnerships between public and private organisations, NGOs and communities;
- developing appropriate referral systems; and
- controlling and treating non-communicable diseases like cancer, heart diseases, mental health problems, diabetes and hypertension.

3.2 Health policies

Sixteen new sub-sectoral policies were introduced in the 1991–2011 period.

1. National Blood Policy, 1993 (Revised in 2005)

The objective of this policy is to ensure adequate, safe and timely supply of blood and blood products to meet the transfusion requirements in an equitable and affordable manner. Following the introduction of this policy the Government mandated the Nepal Red Cross Society as the sole agency responsible for blood collection, storage and supply related services in Nepal. A National Strategic Plan on blood transfusion and related services was drafted for 2009-2013.

2. National Drug Policy, 1995

This policy, which is currently being revised, was formulated to increase the domestic production of drugs, and calls for:

- the rational use of drugs;
- increasing the domestic production of drugs;
- the production of pharmacy related human resources for health; and
- restructuring the Department of Drug Administration (DDA) for the effective implementation of the Drug Act.

3. National AIDS Policy, 1995 (updated in 2011)

This policy calls for:

- high priority to be given to the prevention and treatment of HIV/AIDS and sexually transmitted diseases;
- conducting multi-sectoral decentralised programmes to combat HIV/AIDS; and
- the integration of HIV prevention in other programmes by government and non-government agencies.

4. National Mental Health Policy, 1995

This policy calls for ensuring the availability and accessibility of mental health services for all people in Nepal by:

- producing human resources for mental health;
- promoting respect for the human rights of mental patients;
- formulating legislation to ensure the fundamental human rights of the mentally ill; and
- improving awareness about mental health, and mental disorders and promoting mental health friendly lifestyles.

5. National Ayurveda Health Policy, 1996

The policy calls for promoting, preserving, and developing ayurvedic treatment and promoting research on ayurveda by:

- producing quality ayurveda health personnel by establishing a National Institute of Ayurveda;
- expanding the provision of ayurvedic medicine in VDCs, district and regions;
- providing specialised ayurveda services in central hospitals;
- orienting health workers on the use of local herbs; and
- making ayurvedic health care cost-effective and available to communities in remote areas.

6. National Safe Motherhood Policy, 1998

The Safe Motherhood policy calls for reducing mortality and morbidity of women during pregnancy, childbirth and in the post-natal period by:

- improving maternity care services including family planning at all levels of health care delivery and in communities; and
- improving the general status of women by bringing attitudinal, behavioural and societal change.

7. National Health Research Policy, 2003

The policy calls for health research focusing on equity and social justice and to facilitate health improvements by:

- establishing links between health research and the national health policy;
- promoting health research on all aspects of health;
- ensuring the availability of human and financial resources for carrying out health research; and
- facilitating collaboration and networking between health research stakeholders to promote inter-sectoral participation and international linkages.

8. National Oral Health Policy and Strategies, 2004

This policy calls for the provision of high quality, effective, basic oral health care to all people at all levels including promotive, preventive, curative and rehabilitative care.

9. National Nutritional Policy and Strategies, 2004

The goal of this policy is the nutritional well-being of all people in Nepal through collaboration of the health sector with other relevant sectors to run nutrition programmes.

10. National Safe Abortion Policy, 2006

The policy calls for expanding access to safe abortion services by:

- legalising abortion services;
- defining standards for safe abortions;
- increasing awareness about safe abortion with involvement of government, INGOs, private sectors and other stakeholders; and
- protecting the rights of women to continue or discontinue unwanted pregnancies within the legal framework with involvement from government, INGOs, private sectors and other stakeholders.

11. National Skilled Birth Attendants (SBA) Policy, 2006

The goal of this policy was to ensure a sufficient number of skilled birth attendants are trained and deployed at primary health centre level and provided with necessary support. It calls for:

- defining the role and skills of skilled birth attendants, which has led to the introduction of relevant training on this subject for all eligible health personnel;
- strengthening safe motherhood and new-born programmes at district hospitals;
- strengthening pre-service and in-service training to skilled birth attendants;
- developing, introducing and strengthening regulating, accrediting and licensing systems for skilled birth attendants; and
- strengthening referral systems for safe motherhood and newborn care (district hospitals).

12. Health Care Technology Policy, 2006

This policy promotes quality health service provision by health facilities through the appropriate use of technology by:

- establishing a supportive system for promoting appropriate technology in the health system;
- improving the planning and purchasing system of health service technology, equipment and services;
- creating an appropriate environment for producing human resources for health technology; and
- promoting the effective use of equipment, and the cost-effective use of technology and good clinical practices.

13. Policy on Quality Health Services, 2007

This policy calls for systems to ensure quality health services at all health facilities by:

- developing quality assurance in essential health care service delivery;
- developing standards for quality services;
- developing partnerships with non government and private organisations and communities to ensure quality health services;
- developing and implementing community monitoring and evaluation of health service provision.

14. Free Essential Health Care Policy, 2008

The Interim Constitution of Nepal, 2007 gave every citizen the right to basic health services free of cost as provided by law. The Free Essential Health Care Policy, 2008 called for the provision of free basic health services at all public health facilities. The policy aims to increase access to and use of health

services especially by poor and marginalised people, women and children. In 2008 the first budget after Nepal had been declared a republic removed user charges for basic health care.

16. Free Delivery Policy, 2009

To accelerate the use of skilled birth attendants, the Safe Delivery Incentive Programme (SDIP) was adopted by the government in 2005. The Free Delivery Policy, 2009 subsequently called for:

- providing women with cash incentives and transport subsidies to attend public health facilities to give birth;
- free delivery services at health facilities;
- incentives to health workers for attending home deliveries.

3.3 Health strategies

The government introduced four health strategies between 1998 and 2004.

1. National Reproductive Health Strategy, 1998

Nepal, as a signatory to the Cairo Plan of Action in 1994, committed to providing reproductive health services throughout Nepal. The National Reproductive Health Strategy, 1998 defined reproductive health services as a new approach to strengthen existing safe motherhood, family planning, HIV/AIDS, child survival and nutrition interventions with a holistic life-cycle approach. The policy calls for:

- providing reproductive health services throughout Nepal;
- strengthening existing safe motherhood, family planning, HIV/AIDS, child survival and nutrition programmes;
- including safe motherhood, family planning, HIV/AIDS, child survival and nutrition programmes within reproductive health services; and
- providing reproductive health service packages at different levels.

2. National Adolescent Health and Development Strategy, 2000

The National Adolescent Health and Development Strategy, 2000 calls for improving the health and socio-economic status of adolescents by:

- increasing access to and availability of adolescent health and development services; and
- creating a safe and supportive environment for adolescents to improve their legal, social and economic status.

3. Health Sector Strategy: An Agenda for Reform, 2003

The goal of this strategy was the achievement of the Millennium Development Goals for health. The government formulated this strategy to call for an equitable high quality health care system for people living in remote and rural places and especially for women and children and poor, vulnerable and excluded people by:

- adopting a sector wide approach (SWAp) to health service provision;
- providing an equitable high quality health care system for people in remote and rural places especially targeted at women and children and poor, vulnerable and excluded people; and
- providing quality health services.

4. National Neonatal Health Strategy, 2004

The National Neonatal Health Strategy 2004 calls for improving the health and survival of new born babies in Nepal by achieving sustainable increases in the adoption of healthy newborn care practices and reducing prevailing harmful practices.

3.4 Health plans and programmes

The government introduced three long term plans for the health sector.

1. Second Long Term Health Plan, 1997-2017

The Second Long Term Health Plan is a 20 year perspective plan. It has strategies for improving the efficiency and effectiveness of the public health care system. It offers guidance and support to private and NGO sectors and assists external development partners to direct financial and technical resources to improve the health situation in the country. It calls for:

- improving the health status particularly of those whose health needs are often not met — vulnerable people, women and children, rural people and poor, under-privileged and marginalised people;
- extending essential health care services at all public health facilities;
- developing an appropriate number and type of technically competent and socially responsible health personnel particularly in rural areas;
- improving the management and organisation of the public health sector;
- developing appropriate roles for NGOs and for public and private sector participation in health; and
- improving inter-and intra-sectoral coordination and supporting the effective decentralisation of health care services with full community participation.

2. Nepal Health Sector Programme — Implementation Plan, 2004-10 (NHSP-IP)

NHSP-IP was developed to implement the Health Sector Strategy: An Agenda for Reform (2003). It provides operational guidelines for implementing this strategy. It called for:

- increasing the coverage and quality of essential health care services.
- developing an efficient health sector management system with adequate financial resources.

3. Second Nepal Health Sector Programme — Implementation Plan, 2010-15

The Second Nepal Health Sector Programme aims to improve the health and nutritional status of the Nepali population especially poor and excluded people. This is to happen by the government providing equal opportunities to receive high-quality affordable health care services free of charge. This plan provides strategic direction to the Ministry of Health and Population to achieve its objectives and calls for:

- increasing access to and the use of quality essential health care services;
- reducing cultural and economic barriers to access to health care services and harmful cultural practices in partnership with non state actors; and
- achieving the universal coverage of essential health services.

4 CHANGES IN HEALTH INDICATORS AND DETERMINANTS OF HEALTH

The 20 years since the introduction of the National Health Policy, 1991 has seen a very large increase in the number of health facilities (see Tables 7 and 8), substantial improvements in health indicators (see Table 9), reduced population growth and a changing demographic profile (see Table 10) and other changes in Nepali society.

The other changes that determine health include:

- reduced poverty —from 42% Nepalis living below the poverty line in 1995/96 to 25.2% in 2010/11;
- improved access to information and communication facilities;
- increased literacy and education, especially among women and girls; and
- increased urbanisation.

Table 7: Change in number of health facilities 1991–2011

	1991	2011
No. of government hospitals	77[7]	95[9]
No. of private hospitals	19[7]	113[9]
No. of teaching hospitals	1[7]	18[9]
No. of health facilities below district level	834[7]	4,000[9]

Table 8: Number of hospitals and hospital beds, 2009/10

Type	No of Hospitals	No of beds
Government hospitals	95	6,601
Medical colleges and teaching hospitals	15	9,076
Private hospitals	105	4,621
Army and police hospitals	2	900
Civil service hospital	1	136
Mission hospitals	8	612
Total	**223**	**21,946**

Source: Internal records of Management Division of the Department of Health Services, 2010

Table 9: Changes in Millennium Development Goal and other health indicators

MDG	1990	2010
Infant mortality rate (per 1,000 live births)	108	41
Under-five mortality rate (per 1,000 live births)	162	50
Proportion of one-year-olds immunised against measles	42%	>90%
Maternal mortality ratio (per 100,000)	850	229
Percentage of births attended by skilled birth attendant	7%	60%
Life expectancy	53 years	65.7 years (2006)
Fertility rate (children/women aged 15-49 years)	4.1 children	2.6 children

Sources: Millennium Development Goals progress report, 2010 and Nepal Human Development Report, 2009 and Nepal Health and Demographic Survey (NDHS) 2011

Table 10: Changes in population, 1991–2011 (Source: national census 1991 and 2011 [CBS])

	1991	2011
Population	18.5 million[1]	26.6 million[2]
Population growth rate	2% (1991-2001)	1.4% (2011–2011)
Urban population	9.2%[1]	17.0%[2]
0-4 years	14.6%[1]	11.2%[3]
5-9 years	15.2%[1]	12.4%[3]
10-14 years	12.6%[1]	13.6%[3]
15-49 years	46.0%[1]	46.6%[3]
50-59 years	5.8%[1]	7.8%[3]
60+ years	5.8%[1]	8.4%[3]

Sources: 1. Census results of 1991,CBS; 2. Preliminary report of 2011 Census, CBS; 3. Nepal Demographic and Health Survey, 2011, MoHP

5 STAKEHOLDER PERCEPTIONS ON ISSUES FOR INCLUSION IN NEW HEALTH POLICY

This review consulted a range of central level health stakeholders to find out their perceptions on the National Health Policy, 1991 and identify issues to be considered in a new health policy. Consultations were held with the representatives of government, non-government, civil society, academia and international development agencies listed in Annex 1. The following issues were identified.

1. General issues

- The health policy review should serve as a building block for making the next health policy by providing a list of issues to be considered. This review should look at the entire health system with a fresh-mind.
- It would be best to wait for the new constitution to be promulgated before formulating a new policy.
- The new health policy should be broad enough to include issues not only of the health sector but also of population and nutrition. The new policy should cover the social determinants of health.

The National Health Policy, 1991:

- focused mainly on rural areas and said little on the health needs of urban people;
- called for upgrading the health standards of the majority of the rural population but gave little attention to access to and use of health services by women and children and poor and excluded people;
- did not recommend specific health programmes for women, Dalits, Janajatis, Madhesi, Muslims and disabled people;
- did not deal with inter-sectoral issues such as water, sanitation and health (WASH), medical waste management, climate change, environmental health and geriatric services;
- did not provide any legal entitlement to health care; and
- did not spell out about social security and social health protection issues.

2. Preventive, promotive and curative health services

- Make services available down to the community level through health posts, sub-health posts and female community health volunteers. The integration of health services is effective at the district level but not so at the central level where there is still a vertical system.
- Integrate health education and health promotion into all public health programmes.
- Develop central level hospitals as centres of excellence.
- Do not use tertiary (higher) level health facilities to provide basic health services.
- Make speciality services available beyond the Kathmandu Valley.
- Ensure that referral mechanisms are well-managed with referred clients getting priority and putting feedback mechanisms in place.

3. Expansion of health facilities

- Hospitals, primary health care centres, primary health care centres, health posts and sub-health posts have been established according to geographical and administrative divisions. Now need to

expand health facilities in accordance with population size, especially in urban areas; whilst also considering accessibility (geographical distance) in rural and remote areas.

- Establish urban health services in all municipalities and metropolitan cities.
- Operate at least one health facility with minimum diagnostic facilities in every VDC.
- Expand laboratory and diagnostic services within districts beyond district centres.

4. Organisation and management

- Continue to integrate district hospitals and public health offices into district health offices and evaluate the effectiveness of this restructuring and prevent disagreements between medical officer and public health officers.
- Expand the organisational structure of the Department of Drug Administration to district level to ensure effective monitoring of the drug market.
- Empower regional health directorates.
- Locate health facilities in accessible places. The government should allocate adequate budgets for purchasing land for buildings and expanding health facilities.

5. Human resources for health

- Develop population based policies (establish facilities according to number of people) and strategies for human resources for health.
- Monitor the quality of human resources for health.
- Develop a coordination mechanism for the production and use of human resources for health.
- Train more personnel in the human resources for health categories that are deficient in the health care market (physiotherapists, environmental health technicians, health educators, health economists and other types of health personnel).

6. Deployment and retention

- Reduce the number of non-technical health staff. They currently make up about 60% of human resources in the health sector.
- Make or replace storekeepers with at least assistant pharmacists or health assistants at district level.
- Deploy nutrition supervisors at the district level and nutrition counsellors in all VDCs.
- Post community nurses to provide preventive and promotive services along with training, supervising, monitoring and reporting to staff at primary health care centres, health posts and sub-health posts.
- Increase human resources for health for laboratory services and deploy at least one technician in each district hospital.
- Develop retention strategies for all categories of health workers.

7. Role of private and NGO sectors

- Private sector health facilities should provide free services to poor and disadvantaged people for which they should receive subsidies and incentives from the government.
- Regulate and monitor private health sector service provision.

- Develop a clear and comprehensive policy to attract private and NGO sectors to provide health services.

8. Private medical colleges

- Public hospitals should develop partnerships with private medical colleges. The government should develop a mechanism for such partnerships across the range of health services. These partnerships should also be used during epidemics and disasters.
- Medical colleges should provide preventive as well as curative health services.
- Regulate and monitor the production of service human resources for health by medical colleges.

9. Inter-sectoral coordination and collaboration

- The health sector should take responsibility for inter-sectoral coordination and collaboration on health issues among agriculture, education, water supply, road safety and other sectors.
- Improve the system for inspecting water and food quality in coordination with the Nepal Public Health Laboratory (NPHL).
- Strengthen the Nutrition and Food Security Coordination Committee under the National Planning Commission and make the government's Technical Working Group on nutrition functional.

10. Ayurveda and traditional system of medicine

- Integrate ayurvedic health services into preventive and promotive health services.
- Increase human resources for ayurveda by providing specialist training in and outside the country.
- Update the National Ayurveda Health Policy, 1996.
- Develop Unani and homeopathic health services and provide all alternative systems of medicine under the umbrella of district health systems.

11. Drug supplies

- Provide district health offices with more authority for purchasing their logistics.
- The Department of Drug Administration should establish a quality control laboratory in all five regions to regulate the quality of drugs supplied to government health facilities.
- District drug stores should be managed by assistant pharmacists. They are currently managed by storepersons (store kharidar).

12. Resource mobilisation and community participation

- Increase the budgets allocated to the health sector.
- Allocate adequate resources to meet the increasing demand for public health services that has come about following the introduction of free health services.
- Promote health insurance, community drug programmes and other alternative financing to help finance free health services.
- Ensure community participation at all levels of health services.
- Identify ways of motivating female community health volunteers (FCHVs), such as indirect financial incentives e.g. insurance, free treatment, retirement fund. FCHVs are the largest cadre of health providers at the community level.

13. Health research

- Use the large volume of secondary data available within the government system for research and decision making. Much field based research is done but the evidence is not used in policy making.
- District health managers and health facilities in-charge should have research skills so they can do operational research for evidence-based decision making.
- The health service delivery system should prioritise internationally accepted and proven interventions.

14. Decentralisation

- Continue building the capacity of district and VDC level health facility management committees.
- Strengthen health facility management committees with adequate direct funding.
- Provide block grants to local district and village level bodies that have the capacity to handle funds.

15. Quality of services

The National Health Policy 1991 gives more emphasis on the quantity rather than the quality of services.

- Improve the quality of drugs at public health facilities.
- Introduce integrated supervision and performance-based management for quality service delivery.
- Provide nursing services for curative care according to standard norms; e.g. Human Resources Standard Book, 2005. The guideline should also be followed by private and community health facilities.

16. New topics to be incorporated in new policy

- Establish environmental health, occupational health, health care waste management, mental health and oral health units at the district level.
- Establish rehabilitation centres at the district level for old people, people with disabilities and for nutritional issues.
- Add the control of non-communicable diseases and urban health issues to essential health care services.
- Establish hospitals at the municipal level.
- Implement school health programmes through the pre-service and in-service training of school teachers.
- Establish internet-based recording and reporting systems.
- Strengthen the National Public Health Laboratory (NPHL) for quality control of private laboratory and public health surveillance system and expand laboratory and diagnostic services at the regional level.
- Implement food safety and nutritional supplementation strategies to improve nutritional status. A national Nutrition Institute or Centre should be established to improve institutional capacity.

6 ISSUES FOR THE NEW HEALTH POLICY TO ADDRESS

This review identified a range of issues that should be considered by the new national health policy. The overall issues that should be addressed by the new policy include:

- reaching all citizens with health services (the 1991 policy focussed on reaching rural people);
- taking proactive measures to reach disadvantaged groups with health services;
- ensuring the geographic accessibility of health services, particularly in mountain areas;
- providing quality health services (the 1991 policy focused more on quantity of services).

Many of the following detailed points recommended for coverage in the new health policy fit well with the approaches recommended by the Nepal Health Sector Programme 2 Implementation Plan (2010-15).

6.1 Access to health services

1. Increase access to and use of health services

- Improve the availability, accessibility and use of preventive, promotive, curative and rehabilitative health services.
- Address equity, access and social inclusion as cross-cutting issues in the provision of health services.

2. Improve the provision of essential health care services

- Institute universal coverage of essential health care services, giving priority to the poor, women and children, disadvantaged and excluded groups.
- Extend the provision of mental health, oral health, eye care, geriatric services, environmental health, occupational safety, prevention of non-communicable diseases and expanded nutritional care and support.
- Remove economic, cultural and geographical barriers to service utilisation.

3. Expand health services beyond essential health care

- Address the increasing burden of non-communicable diseases.
- Promote healthy lifestyles through behaviour change communication to prevent non-communicable diseases.
- Extend specialist services to remote places in mountainous and hilly regions.
- Designate national centres of excellence for speciality services and research including for cancer, trauma, heart, kidney, infertility, nutrition and laboratory and diagnostic services.

4. Strengthen and expand health facilities and services

- Strengthen existing health facilities from central to peripheral levels.
- Equip district hospitals with specialty services including comprehensive emergency obstetric care (CEOC) units, paediatrics, anaesthesia, basic surgery, eye care, oral and mental health services.
- Equip all health posts and primary health care centres with birthing centres.
- Expand health facilities on the basis of geography, population density and patient load.

- Establish or upgrade health facilities: sub-health posts to health posts and health posts to rural or community hospitals.
- Scale up urban health services and establish municipal hospitals in all municipalities.
- Strengthen district hospitals by increasing the number of beds and ensuring the availability of infrastructure, laboratory and diagnostic services, human resources, drugs and equipment.
- Improve the provision of specialist services at regional and zonal level hospitals.
- Engage medical colleges and private hospitals and NGOs to provide specialist services.

5. Improve the quality of health services

- Make central hospitals function as referral centres
- Strengthen the referral system
- Strengthen the quality of laboratory, diagnostic and other supportive services at all health facilities.
- Improve the blood transfusion services to ensure timely availability of safe blood and blood products at hospitals
- Review and update the national drug policy to ensure quality of health products.
- Ensure the availability of technically competent and motivated staff.
- Establish a mechanism for assuring quality health services through continuous monitoring and the supervision of public and private sector health facilities.
- License and accredit facilities and health personnel.

6.2 Strengthening the health system

6. Human resources for health

- Adopt 'team posting' at health facilities to ensure the presence of the appropriate mix of skills.
- Improve systems for recruiting, deploying and retaining human resources.
- Plan for and produce all types of required human resources for health.

7. Ayurveda and other traditional systems of medicine

- Recognise ayurveda as an indigenous system of medicine deep rooted in Nepali society and integrate ayurvedic health services at the district level and below.

8. Engaging the private and NGO sectors

- Involve the private and NGO sectors in formulating policies and strategies.
- Engage the private and NGO sectors more in implementing programmes and producing human resources
- Encourage the private and NGO sectors to partner with the public system to expand services in rural areas.
- Promote partnerships between district hospitals, private medical colleges, community hospitals, mission hospitals and cooperatives for providing health services.
- Encourage the private and NGO sectors to provide all types of services including preventive, promotive and rehabilitative services.
- Regulate and accredit the private and NGO health sectors.

- Scale up successful community initiatives and other result-oriented public-private partnership models.

9. Resource mobilisation

- Allocate sufficient funds to ensure free health care.
- Explore introducing social security and social protection measures.
- Implement alternative financing mechanisms for health service provision through implementation of community health insurance and health cooperatives.
- Define a safety-net mechanism and criteria of subsidy for services beyond essential health care services.
- Bring together government, donor and other stakeholders for sustained partnership, coherent and collaborative working with definite goals.

10. Organisational reform

- Restructure all levels of the health system in accordance with decisions made on federal governance.
- Provide logistical, financial, supervisory and technical support from the centre to the periphery.
- Allocate adequate budgets for routine repair and maintenance of health facilities and invest in new construction and refurbishment of health facilities to increase access to health services for poor, vulnerable and marginalised people.
- Make efforts to remove disparities in price, quantity and quality of medicines and other logistics for providing health supplies to remote areas.
- Develop a comprehensive health information system to provide information for input, process and output monitoring.
- Promote operational research for evidence-based decision making.

11. Decentralisation of health service management

- Involve local communities in planning and managing health facilities including resource generation at all levels.
- Provide more flexible block grants to local bodies in the spirit of decentralisation.
- Encourage participatory planning, social and public auditing and mandatory public hearings to improve health service delivery.
- Create an enabling environment to promote community participation and enhance local ownership of health facilities.

12. Inter-sectoral coordination and collaboration

- Coordinate with other sectoral ministries to plan and implement programmes that affect health and its social determinants.

13. Strengthening monitoring mechansin

- Regularly monitor achievements to remove inequities in access to health care and increase use by the poor, rural, excluded groups and women and children of all castes, ethnicities and religions.
- Fix health and health service targets for long and short term periods

14. Ensuring timely formulation of laws and regulations

- Ensure the timely formulation of laws and regulations including on entitlements to health care.

15. Introducing social security and social health protection

- Provide legal protection to health care workers and ensure patients' safety by enacting Health Worker's Protection Act.
- Develop a mechanism for social security and social health protection.

16. Ensuring gender and social inclusuion in health

- Develop a policy to create a favourable environment for mainstreaming gender and social inclusion in health

17. Strengthening and upgrading of health instituitions according to need

- Develop a policy for strengthening and upgrading of health institutions according to need and as envisoned in NHSP II and beyond

18. Pharmaceutical services and care

- Incorporate pharmaceutical services in providing curative care from health facilities at all levels

19. Laboratory and diagnostic services and care

- Develop a policy to strengthen and make laboratory, diagnostic and other services available upto the lowest level of health facilities

20. Blood transfusion services

- Develop a sectoral policy for blood transfusion services
- Establish national blood centre

21. Public private partnership

- Develop a sectoral policy for public private partnership.

22. Environmental health

- Develop a policy for environmental helath addressing the issues of water, sanitation and hygiene, health care waste management, air pollution and climate changes.

23. Disater Preparedness and Emergency Management

- Develop a policy for disaster preparedness and emergency management.

Annex 1: Persons interviewed and other informants

The National Planning Commission
Prof Dr S K Rai, Member, National Planning Commission
Ministry of Health and Population
Dr Praveen Mishra, Secretary, MoHP
Dr P B Chand, Chief, Public Health Administration, Supervision and Monitoring Division
Ms. Ishwari Devi Shrestha, Chief Nurse
Mr Bhupendra Bahadur Thapa, Chief Drug Administrator
Dr B R Marasini, Chief, Health Sector Reform Unit
Dr Bhuwan Paudel, Chief, Ayurveda and Traditional Medicine
Mr. Rishi Lamichhane, Population Division
Mr Kavi Raj Khanal, Policy, Planning and International Cooperation Division
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Dr Y V Pradhan
Mr Laxmi Narayan Deo
Dr Ramesh Kharel
Dr Gita Shakya
Mr B B Khadka
Dr Naresh Pratap KC
Ms. Hem Kala Subba
Mr Chuda Mani Bhandari
Dr. G D Thakur
Dr Mingmar Sherpa
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Dr Ananda Shrestha
Department of Ayurveda
Dr Om Kala Subedi, Director General
Department of Drug Administration
Mr Radha Raman Prasad, Director General, Department of Drug Administration
District Public Health Offices
Mr K B Chand, DPHO, Kathmandu
Mr Bal Krishna Bhusal, DPHO, Lalitpur
Mr Arjun Bahadur Adhikari, DPHO, Bhaktapur
Academia and Civil Society
Dr Arjun Karki, Vice Chancellor, Patan Academy of Health Sciences
Dr Bhola Rijal, President, Association of Private Health Institutions of Nepal
International Development Agencies
Dr Lin Aung
Dr Frank Paulin
Dr Markus Behrend
Dr Susanne Grimm
Mr Ashoke Shrestha
Dr Janardan Lamichhane
Mr Dhrub Bahadur Thapa
Dr Nancy Gerein
Dr L R Pathak

Annex 2: National Health Policy, 1991

Second edition, June 1993 (Ashad 2050 B.S.)

(Unofficial translation)

PRESENT HEALTH STATUS

The present low level health status is attributable to lack of political commitment, inappropriate strategies and weak implementation of health programmes down to the grassroots level during the past 30 years. Because of these weaknesses the crude death rate is 16 per thousand, the crude birth rate is 41 per thousand, child mortality is 107 per thousand, maternal mortality is 8.5 per thousand and the mortality rate of children below five years is 197 per thousand. These facts and figures confirm Nepal as an underdeveloped and backward nation.

Regarding health service delivery, there is only one hospital for every 168,000 persons and one doctor for every 92,000 persons in rural areas. Likewise, only one hospital bed is available for every 4,000 persons. There is only one health post for every 24,000 rural persons, which indicates the inadequacy of primary health care services at the rural level.

MAIN DEFICIENCIES IN PREVIOUS HEALTH SERVICES

1. The policy, objectives and strategies outlined for health services have not been village-oriented and there have been deficiencies in the capability of using the available resources since rural plans and programmes were not formulated as per requirements of rural populations.
2. There were weaknesses in the implementation of plans and programmes.
3. The supervision, monitoring and evaluation of programmes has not been conducted in a regular manner.
4. Resources have been centralised.
5. Posts sanctioned for district level health organisations have not been filled.

RATIONALE OF THE NATIONAL HEALTH POLICY

It is necessary to have a new health policy in order to bring about improvement in the present health conditions of the Nepalese people adversely affected by the previous weaknesses and to fulfil the commitment of the present government in the health sector.

OBJECTIVES OF THE HEALTH POLICY

The primary objectives of the new Health Policy are to upgrade the health standards of the majority of the rural population by extending Basic Primary Health Services up to the village level and to provide the opportunity to the rural people to enable them to obtain the benefits of modern medical facilities by making such facilities accessible to them.

TARGETS OF THE HEALTH POLICY

By the year 2000 AD., the following targets will be attained:

1. The infant mortality rate will be reduced to 50 per thousand from the present 107 per thousand.
2. The mortality rate of children below 5 years will be reduced to 70 per thousand from the present 197 per thousand.
3. The total fertility rate will be reduced to 4 from the present 5.8 children per women of child bearing age.
4. The maternal mortality rate will be reduced to'4 per thousand from the present 8.5 per thousand live births.
5. The average life expectancy will be raised to 65 years from the present 53 years.

HEALTH POLICY, 1991

1. PREVENTIVE HEALTH SERVICES

Services provided for the prevention of diseases are preventive health services. Under these, priority will be given to programmes that directly help reduce infant and child mortality rates. These services will be provided in an integrated way through sub-health care centres at the rural level. The main such programmes are as follows:

a) Family planning and maternal and child health

b) Expanded immunisation

c) Safe motherhood

d) Diarrhoea and acute respiratory infection control

e) Tuberculosis control

f) Leprosy control

g) Malaria and Kalazaar control

h) Control and prevention of communicable diseases

i) Initiation of prevention of non-communicable diseases

j) Initiation of primary health services in urban slums

k) Prevention of AIDS (HIV).

2. PROMOTIVE HEALTH SERVICES

Programmes that enable persons and communities to live healthy lives are promotive health services.

a) ***Health Education and Information*** — One of the main reasons for the low health standards of the people is lack of public awareness of health matters. Therefore, health education will be provided in an effective manner from centre to rural levels. For this, political workers, teachers, students, social organisations, women and volunteers will be mobilised extensively to the ward level.

b) ***Nutrition*** — Priority programmes will be given to promoting breast-feeding, growth monitoring, prevention of iodine deficiency disorders, iron and vitamin A deficiency, and health education to enable mothers to meet the daily requirements of children through locally available resources.

c) ***Environmental Health*** — Programmes to inform the people about personal hygiene through various media; to collect and manage solid wastes; to inspect hotel foods, drinking water and other edible products and the construction of general latrines and urinals, will be initiated in a coordinated manner.

3. CURATIVE HEALTH SERVICES

The following curative health services will be made available at central, district and village levels:

a) Preventive, promotive and curative health services will be made available in an integrated way in rural areas through sub-health posts, health posts and primary health care centres.

b) There will be at least one hospital in each district of Nepal where out-patient services, in-patient services, family planning and maternity and child health services, immunisation services and emergency services will be provided.

c) One zonal hospital will be established gradually in each of the zones of the kingdom. Specialised services relating to paediatrics, gynaecology, general surgery, general medicine and eye care will be available there.

d) one regional hospital will be established gradually in each of the five regions of the kingdom. In these hospitals, specialised services e.g. dermatology, orthopaedics and psychiatry will be available in addition to those available in zonal hospitals.

e) Central hospitals will be equipped with sophisticated diagnostic and other facilities and will provide specialty and super-specialty services.

f) Specialist services will be provided to remote mountain regions, as and when required, through mobile teams.

g) A referral system will be developed through which the rural population will be provided with the opportunities to obtain services from modern well equipped hospitals, as and when required.

h) Diagnostic services e.g. laboratory, x-ray and other supportive services will be strengthened in hospitals all levels.

4. BASIC PRIMARY HEALTH SERVICES

a) Sub-Health Posts will be established in a phased manner in all village development committee areas of the Kingdom. Each sub-health post will employ one village health worker, one maternal and child health worker and one auxiliary health worker. These sub-health posts will provide general curative, promotive and preventive health services. Immunisation, family planning, maternity and child health, health education, nutrition, environmental education, sanitation, and treatment of Malaria, Leprosy and Tuberculosis will also be provided by these sub-health posts, up to the ward level.

b) One health post in the 205 electoral constituencies of the kingdom will be upgraded in a gradual manner and converted to a primary health care centre. In addition to the services provided by sub-health posts, arrangements will be made for two emergency beds and one maternity bed in these centres.

c) The health posts operating at present will provide all health services in village development committees where they are located as is done by sub-health posts and will also provide training for and supervise and monitoring of the activities of sub-health posts.

5. COMMUNITY PARTICIPATION IN HEALTH SERVICES

Community involvement will be sought at each level of health care. The participation of women volunteers, traditional birth attendants *(sudenis)* and local leaders of various social organisations will be mobilized for health programmes at the ward level.

6. ORGANISATIONAL AND MANAGEMENT REFORM

a) Improvements will be made in the organisation and management of health facilities at the central, regional and district levels. Hospitals and public health offices at district levels will be operated in an integrated way under one organisation.

b) The technical and administrative supervision and follow-up system for health organisations at various levels will be made more effective.

c) Hospitals and health facilities at different levels will be classified. A detailed description of the services available at the health facilities at different levels cost of the services and list of free services will be prepared and made public.

d) The collection, compilation, recording and reporting systems for health information at each level will he made more effective.

e) Improvements will be made in the transportation and support systems for drugs and equipment at various health facilities.

7. DEVELOPMENT AND MANAGEMENT OF HEALTH MANPOWER

a) Capable manpower required for various health facilities will be developed in a planned manner.

b) Necessary cooperation will be extended for institutional development of the Institute of Medicine — the main organisation *of* the country producing health manpower, in order to raise its production capacity.

c) Necessary arrangements for training in foreign countries will be made in order to produce those categories of manpower that cannot be produced within the country.

d) The training centres under the Ministry of Health will be strengthened institutionally and their production capacity will be raised, as required.

e) Necessary reforms will he made in transfer, promotion and career development procedures for health personnel at various levels.

f) Arrangements will be made to provide special benefits for doctors and other health personnel to encourage them to work in remote rural areas.

8. PRIVATE, NON-GOVERNMENT AND INTER SECTORAL COORDINATION

a) If anyone in the private sector wants to extend health services by establishing hospitals, health units, nursing homes, without any financial liability to His Majesty's Government, such institutions may be operated after having obtained necessary permission from His Majesty's Government and subject to prescribed minimum standards.

b) Non-government organisations and associations will be encouraged to provide health services under the prescribed policies of His Majesty's Government.

c) Necessary coordination will be maintained at each level with health-related sectors including agriculture, education, drinking water and local development.

9. AYURVED AND OTHER TRADITIONAL HEALTH SYSTEMS

a) The Ayurvedic system will be developed in a gradual manner. Organisational structures for different levels will be prepared separately. This type of medicine will be developed and expanded on the basis of evaluation of services through research.

b) Encouragement will be provided, as possible, to other traditional health system like unani, homeopathy and naturopathy.

10. DRUG SUPPLY

a) To improve the supply of drugs in government health organisations as well as health facilities operated by the private sector, the domestic production of essential drugs will be increased. In the meantime, the quality of the drugs will be upgraded by effective implementation of the National Drug Policy.

11. RESOURCE MOBILISATION IN HEALTH SERVICES

a) National and international resources will be mobilised for health services. National and foreign donor agencies will be requested to provide necessary cooperation for providing resources to implement the programmes under this Health Policy of His Majesty's Government.

b) Various alternative measures for resource mobilisation for health services will be the subject of experiment including health insurance, user's charges, revolving drug schemes and so forth.

12. HEALTH RESEARCH

a) Research in the health sector will be encouraged. The outcome of research will be applied in decision making for better management of health services.

13. REGIONALISATION AND DECENTRALISATION

a) Regionalisation and decentralisation processes will be strengthened. Peripheral health units will be made more autonomous and effective. for this, amendments will be required in the existing decentralisation regulations.

b) Of the various organizations providing health services at different levels, the district health organisations will be given the most prominent role. Arrangements will be made for the local level planning and management of curative and promotive health services, with priority given to preventive health services, from the district to village levels.

c) Micro-planning procedures will be adopted in formulating primary health plans at the village level under which health services will be provided to all target groups with special efforts to reach underprivileged groups.

14. BLOOD TRANSFUSION SERVICES

a) The Nepal Red Cross Society will be the only authorised organisation to conduct all programmes related to blood transfusion.

b) To run different programmes related to blood transfusion the Nepal Red Cross Society will seek consent of the Ministry of Health and will run such programmes.

c) The practice of buying, selling and depositing of blood will be prohibited.

15. MISCELLANEOUS

a) Safety standards will be developed for industrial establishments for the health security of workers engaged in industries and their implementation will be monitored.

b) Laws and regulations relating to health will be formulated as necessary.

c) Extensive publicity will be carried out on the hazardous effects of drug abuse, alcoholic drinks and smoking.

d) Programmes relating to the welfare of disabled and handicapped persons will be prepared in coordination with the private sector and non-government organisations.

Appendix 1 (of NHP 1991): Health infrastructure and population ratio

Population ratio	Proposed health unit	Number	Levels of infrastructure
1:4,000	Sub-health posts	3,199	1 per VDC
1:29,000	Health posts	611	1 per every 5 VDCs
1:100,000	Primary health centres	205	1 per electoral constituency
1:200,000	District health offices/ district hospitals	75	1 per district
1:1,300,000	Zonal hospitals	14	1 per zone
1:3,600,000	Regional hospitals	5	1 per region
	Central hospitals		Super speciality/teaching facilities

Appendix 2 (of NHP 1991): Health Infrastructure from District to Village levels

District Health Office

District Hospital – 75	**District Public Health Section – 75**
Electoral Constituency Level	**Primary Health Centre – 205**
	Medical Officer -1
	Health Assistant -1
	AHW 3
	ANM – 3
	VHW 1
	Sweeper 2
	Beds (maternity 1, other 2)
District Division Level	**Health Post - 611**
	Health Assistant -1
	AHW - 2
	ANM – 2
	VHW - 1
Village Development Committee Level	**Sub-health post – 3,199**
	Health Assistant – 1
	AHW – 1
	ANM - 1
Ward level	Ward level volunteers – 48,000
	Political workers
	FCHV
	TBA

Appendix 3 (of NHP 1991): Organisational Structure of the Ministry of Health