ORIGINAL RESEARCH ARTICLES

Analysis of Health, Disability, Gender and Disaster Risk Reduction Policies in Nepal using a Human Rights-based Approach

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ABSTRACT

Purpose: *This study assessed the extent to which the issues of vulnerable groups, such as persons with disabilities, women and girls, are incorporated in line with human rights principles in the key policies related to health, disability, gender, and disaster risk reduction in Nepal.*

Method: *A content analysis was carried out using EquiFrame, which analyses policies for the inclusion of vulnerable groups based on the Core Concepts of Human Rights. Fifteen policies were analysed regarding the quality and frequency with which persons with disabilities, women, and girls were included in the documents.*

Results: *Nepal's health policy (n=4) covered 52% of the Human Rights Core Concepts, while policies on disability (n=3), gender (n=2), and DRR (n=6) covered 46%. The overall qualities of those policies were ranked significantly low, with quality index ranging from 8 - 28.*

Conclusion: *The policies inadequately incorporated human rights principles for the inclusion of disability and gender, and were ranked low quality in addressing their health needs and rights. To enhance social inclusion and promote equity in health, it is suggested that the human rights approach guided by EquiFrame be followed while developing policies.*

Key words: *disability, disaster, EquiFrame, gender, health, human rights, policy analysis, Nepal*

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INTRODUCTION

The World Report on Disability 2011 shows that an estimated one billion people comprising 15% of the world population are living with a disability, and 80% of them live in developing countries (World Health Organisation & The World Bank, 2011). It is also estimated that the prevalence of disability among women is higher (60%) than among men (Hosseinpoor et al, 2012). The literature suggests that women with disabilities face multiple disadvantages and exclusions, including disparities in healthcare on account of their gender and disability (Devkota et al, 2018; Mac-Seing et al, 2020). Moreover, women with disabilities are more likely to have unmet healthcare needs than women without disabilities.

Studies in different countries show that persons with disabilities, particularly women and girls, are disproportionately affected by disasters and are at greater risk of injury, death, or long-term negative impacts on their health and wellbeing due to the difficulties in accessing healthcare and life-saving procedures during and after disasters (World Bank Group & GFDRR - Global Facility for Disaster Reduction and Recovery, 2017). A study in Bangladesh revealed the increase in perineal rashes and urinary tract infections in women and girls during floods and starvation post-floods due to the destruction of crops, posing a critical danger to the survivors, particularly to pregnant women, lactating mothers, and children (Ahmed, 2013). At the time of an emergency or in disaster situations, persons with disabilities are less likely to be evacuated, and their possible exposure to the risk of injury and death can be high (UN DESA, n.d.).Moreover, studies also suggest that these vulnerable groups of the population face greater threats to their survival and recovery in the aftermath of disasters (Priestley & Hemingway, 2007).

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) 2006, and the Sendai Framework for Disaster Risk Reduction 2015, both ensure the protection of persons with disabilities and lay out expectations regarding the inclusion of the rights of persons with disabilities in situations of risk and humanitarian emergencies (United Nations, 2006, 2015). The Sendai Framework (2015–2030) emphasises the need to integrate gender, age, disability, and cultural perspectives in all policies and practices, and its guiding principles include empowerment and inclusive, accessible, and non-discriminatory participation of vulnerable groups and those disproportionately affected by disasters (United Nations, 2015). Moreover, the importance of promoting inclusive DRR has been progressively articulated in Asia Pacific regional declarations and

action plans such as the New Delhi Declaration on Disaster Risk Reduction in Asia and the Pacific – 2016, that emphasises the participation and leadership of women, children and persons with disabilities. In respect of the CRPD and Sendai Framework, the UN calls for all member states to include a disability perspective in their policies and practices. However, it is not known how the policies and health systems in developing countries like Nepal have addressed the needs of these vulnerable populations during disaster situations. It is not known if the key policies and legislations in Nepal incorporate human rights principles or how those policies are translated into practice. To the best of the authors' awareness, the policies in Nepal have not yet been analysed to fill the gaps in knowledge.

Objective

This study aimed to assess the extent to which Nepal's key health, disability, gender, and disaster risk reduction policies cover the core concepts of human rights and the inclusion of persons with disabilities, women, and girls.

METHOD

Study Design

A policy analysis framework, EquiFrame (Mannan et al, 2011), was used to evaluate the selected policies. Initially used in health policy analysis, it follows the human rights approach to policy analysis and is now used in other sectors as well, e.g., disability, economic empowerment, international donor's policies (MacLachlan et al, 2016).

Selection of Policies

The latest policies related to health, disability, gender, and disaster risk reduction formulated by federal and local governments, if any, with the study districts were included for analysis.

The key criteria used for the selection were:

- National Health Policies, Acts, and strategies formulated by the Federal Ministry of Health and Population (MoHP), provincial ministries and local government in the project area. (This policy analysis was one of the activities of 'Gender Responsive Resilience and Intersectionality in Policy and Practice [GRRIPP] South Asia', a study which was implemented in Palungtar and Marsyangdi Municipalities of Gorkha and Lamjung districts respectively.)

- National Disability Policies, Acts, Health Service guidelines, and Periodic plans formulated by the Federal Ministry of Women, Children and Senior Citizens (MoWCSC), provincial ministries and local government in the project area.
- National Gender Policies formulated by the Federal MoHP, MoWCSC, provincial ministries, and local government in the project area.
- National Disaster Risk Reduction Policies, Acts, and guidelines formulated by the Federal Ministry of Home Affairs (MoHA), provincial ministries and local government in the project area.

All these policies were searched using the respective Ministry and local government websites, and the documents were downloaded for analysis.

Table 1 presents the list of policies and Acts related to health, disability, gender, and disaster risk reduction included for analysis.

Table 1: Policies included for Analysis by Sector

Policies
Health Policies
• National Health Policy – 2019 - MoHP
• Public Health Service Act – 2077 [2020]
• National Strategy for Reaching the Unreached – 2073 [2016] - MoHP
• Gandaki Province Health Policy – 2078 [2021]
Disability Policies
• National Guidelines for Disability Inclusive Health Services - 2019
• Disability Related Ten Year National Policy and Plan (2073 – 2082) - 2016
• The Act Relating to Rights of Persons with Disabilities - 2074 [2017]
Gender Policies
• Gender Equality and Social Inclusion Strategy of the Health Sector – 2018-MoHP
• National Gender Equality Policy – 2077 [2020]-MoWCSC
Disaster Risk Reduction Policies
• National Policy for Disaster Risk Reduction – 2018 - MoHA
• DRR National Strategic Plan of Action 2018 – 2030 [2018] - MoHA
• Disaster Risk Reduction and Management Act, 2074 and Rules - 2076 [2019]-MoHA
• DRR Act 2075 [2018], Palungtar Municipality, Gorkha
• DRR Act 2075 [2018], Marsyangdi Rural Municipality, Lamjung
• Disability Related Ten Year National Policy and Plan - DRR (2073 – 2082) [2016]

Data Collection

The study analysed the contents of the policy documents by developing a data extraction matrix that was constructed with the vertical axis listing the 21 predefined Core Concepts of Human Rights mentioned in the EquiFrame (Mannan et al, 2011),and the horizontal axis containing vulnerable groups that were categorised as – persons with disabilities, women/girls. Each policy document was read to identify the vulnerable group mentioned in the document, and the frequencies and score were recorded following the EquiFrame Manual.

EquiFrame

EquiFrame was originally developed by Ahfad University for Women, Sudan, and the Centre for Global Health at Trinity College Dublin, which considers social inclusion and human rights as key components of equity in the context of service provision. It identifies the degree of commitment of the policy to specified vulnerable groups and to the Core Concepts of Human Rights.

Table 2 below presents the EquiFrame's 21 core concepts, alongside the key questions and key language to elucidate the specified core concepts. However, they are not positioned in terms of equivalent importance within the framework, but rather are included with a view to representing a broad range of salient concerns in striving for equitable, accessible, and universal healthcare.

Table 2: EquiFrame's Core Concepts, Key Questions and Key Languages

No.	Core Concept	Key Questions	Key Language
1	Non-discrimination	Does the policy support the rights of people with disabilities and women/girls with equal opportunity in receiving health care?	People with disabilities and women/ girls (Vulnerable groups) are not discriminated against on the basis of their distinguishing characteristics (i.e., Living away from services; Persons with disabilities; Ethnic minority or Aged).
2	Individualised Services	Does the policy support the rights of people with disabilities and women/girls with individually tailored health and rehabilitation services to meet their needs and choices?	People with disabilities and women/ girls receive appropriate, effective, and understandable services.

3	Entitlement	Does the policy indicate how people with disabilities and women/girls may qualify for specific benefits relevant to them?	People with limited resources are entitled to some services free of charge or persons with disabilities may be entitled to respite grants.
4	Capability- based Services	Does the policy recognise the capabilities existing within people with disabilities and women/girls?	For instance, peer to peer support among women-headed households or shared cultural values among ethnic minorities.
5	Participation	Does the policy support the right of people with disabilities and women/girls to participate in the decisions that affect their lives and enhance their empowerment?	People with disabilities and women/girls can exercise choices and influence decisions affecting their life. Such consultation may include planning, development, implementation, and evaluation.
6	Coordination of Services	Does the policy support assistance of people with disabilities and women/girls in accessing services from within a single provider system (intra-agency) or more than one provider system (inter-agency) or more than one sector (inter-sectoral)?	People with disabilities and women/ girls know how services should interact where inter-agency, intra-agency, and inter-sectoral collaboration is required.
7	Protection from Harm	Does the policy outline that people with disabilities and women/girls are to be protected from harm during their interaction with health/disaster and related services?	People with disabilities and women/ girls are protected from harm during their interaction with health and related systems.
8	Liberty	Does the policy support the right of people with disabilities and women/girls to be free from unwarranted physical or other confinement?	People with disabilities and women/ girls are protected from unwarranted physical or other confinement while in the custody of the service system/provider.
9	Autonomy	Does the policy support the right of people with disabilities and women/girls to consent or refuse to consent, withdraw consent, or otherwise control or exercise choice or control over what happens to them?	People with disabilities and women/ girls can express "independence" or "self-determination". For instance, a person with an intellectual disability will have recourse to an independent third-party regarding issues of consent and choice.

10	Privacy	Does the policy address the need for information regarding people with disabilities and women/girls to be kept private and confidential?	Information regarding people with disabilities and women/girls need not be shared among others.
11	Integration	Does the policy promote the use of mainstream services by people with disabilities and women/girls?	People with disabilities and women/ girls are not barred from participation in services that are provided for the general population.
12	Contribution	Does the policy recognise that people with disabilities and women/girls can be productive contributors to society?	People with disabilities and women/girls make a meaningful contribution to society.
13	Family Resource	Does the policy recognise the value of the family members of people with disabilities and women/girls in addressing health needs?	The policy recognises the value of family members of people with disabilities and women/girls as a resource for addressing health needs.
14	Family Support	Does the policy recognise individual members of people with disabilities and women/ girls may have an impact on the family members requiring additional support from health services?	Persons with chronic illness may have mental health effects on other family members, such that these family members themselves require support.
15	Cultural Responsiveness	Does the policy ensure that services respond to the beliefs, values, gender, interpersonal styles, attitudes, cultural, ethnic or linguistic aspects of the person, as well as personal safety and dignity?	i) People with disabilities and women/ girls are consulted on the acceptability of the service provided. ii) Health facilities, goods and services must be respectful of ethical principles and culturally appropriate, i.e., respectful of the culture of people with disabilities and women/girls.

16	Accountability	Does the policy specify to whom, and for what, services providers are accountable?	People with disabilities and women/girls have access to internal and independent professional evaluation or procedural safeguards.
17	Prevention	Does the policy support people with disabilities and women/girls in seeking primary, secondary, and tertiary prevention of health conditions associated with disaster?	
18	Capacity Building	Does the policy support the capacity building of health/emergency support workers and of the system that they work in addressing health needs of people with disabilities, women/girls?	
19	Access	Does the policy support people with disabilities and/or women/girls—physical, economic, and information access to health services?	People with disabilities and women/girls have accessible health facilities (i.e., transportation; infrastructure; affordability and understandable information in appropriate format).
20	Quality	Does the policy support quality services to people with disabilities and women/girls through evidence-based and professionally skilled practice?	People with disabilities and women/girls are assured of the quality of the clinically appropriate services.
21	Efficiency	Does the policy support efficiency by providing a structured way of matching health system resources with service demands in addressing health needs of people with disabilities, women/girls?	

This study assessed the inclusion of two categories of vulnerable groups. They were persons with disabilities and women/girls. In each document, the presence of Core Concepts was assessed for vulnerable groups – persons with disabilities, women, and girls - that were mentioned in the policy. If the policy did not mention

vulnerable groups but the concept was found addressing the total population stating "all people", this was categorised as "Universal".

Table 3: Vulnerable Groups and its Definition

Vulnerable Groups	Attributes or Definitions
Persons with Disabilities	Physical, sensory, intellectual or mental health conditions, and including synonyms of disability
Women and Girls	Referring to the female gender

Data Analysis

Measures, Scoring and Procedure

Core concepts (CCs) mentioned individually or collectively were counted by categorising them as disability, gender, or universals. Core Concept frequency, coverage, and the quality of commitment to the Core Concepts were measured and the result of each policy, by sector and in aggregate, is presented quantitatively. Each Core Concept identified in the policy documents listed was scored on a scale ranging from 1 to 4, following the criteria of:

1 = Concept only mentioned,

2 = Concept mentioned and explained,

3 = Specific policy actions identified to address the concept,

4 = Intention to monitor the concept was expressed.

Indices to measure "Core Concept Coverage", "Core Concept Quality" and "Overall Summary Ranking" were developed. **Core Concept Coverage** was measured with respect to the number of Core Concepts mentioned from among the 21 predefined framework concepts, and this ratio is expressed as a percentage. Similarly, **Core Concept Quality** was measured with respect to the number of Core Concepts within it, that were rated as 3 or 4 (as either stating a specific policy action to address a Concept or an intention to monitor a Concept) out of the 21 Core Concepts, and the ratio is expressed as a percentage. When several references to a Core Concept were identified, the mean quality score for the

respective concept was recorded. The **Overall Summary Ranking** of the policy document is stated as High, Moderate, and Low, following the criteria:

- High = if the policy achieved ≥50% on all of the three scores above,
- Moderate = if the policy achieved ≥50% on two of the three scores above,
- Low = if the policy achieved <50% on two or three of the three scores above.

Qualitative data was extracted for each of the predefined Core Concepts and vulnerable groups mentioned as person with disability or disability, women/girls or gender, vulnerable group in common, and this was analysed and compared to ensure inter-rater reliability. All policy documents were assessed and rated by two authors independently using EquiFrame Matrix. The total number and scores for the mentioned Core Concepts and vulnerable groups were calculated for each document. In the case of disagreement between two authors in concept extraction and scoring, a consensus decision was reached through discussion with the other team members.

RESULTS

Table 4 reveals that the frequency and average quality scores of Core Concepts of disability, gender, and universal mention of vulnerable groups (stating all populations) in the four health policy documents were 50 (2.6), 34 (3.2) and 19 (1.8) respectively, meaning that there were low frequency references and quality scores. Similarly, the frequencies and average scores for those group concepts in the three disability policies were 175(3), 17(3.4) and 2 (3) respectively, meaning that disability received more frequent coverage, although quality scores were comparable. In the policies related to disaster risk reduction, the frequencies and their average scores were 46 (2.5), 41 (2.6), and 13 (2.3) for disability, gender, and universal coverage respectively, meaning that the policies were less frequently mentioned and poorly explained than the health and disability policies. Two gender policies which made least mention of the concepts, had the frequencies and their average score as 15 (2.9), 28 (3.4), and 16 (2.9) for disability, gender and universal coverage respectively.

Table 4: Reference Frequencies and Average Scores by Sector and Policy Documents

Sectors	Disability		Gender		Universal (All population)	
	Ref. frequencies	Average score	Ref. frequencies	Average score	Ref. frequencies	Average score
Health Policies	**n=50**	**2.6**	**n=34**	**3.2**	**n=19**	**1.8**
• National Health Policy – 2019	4	2	9	3.1	10	2.1
• Public Health Service Act - 2077	6	4	9	4	-	-
• National Strategy for Reaching the Unreached – 2073 MoHP	32	3.1	10	3.9	-	-
• Gandaki Province Health Policy - 2078	8	1.3	6	1.8	9	1.5
Disability Policies	**n=175**	**3**	**n=17**	**3.4**	**n=2**	**3**
• National Guidelines for Disability Inclusive Health Services – 2019	73	2.5	4	4	-	-
• Disability Related Ten Year National Policy and Plan (2073 – 2082)	66	3.7	11	3.2	1	2
• The Act Relating to Rights of Persons with Disabilities - 2074 (2017)	36	3.1	2	4	1	4
Gender Policies	**n=15**	**2.9**	**n=28**	**3.4**	**n=16**	**2.9**
• Gender Equality & Social Inclusion Strategy of Health Sector – 2018 MoHP	15	2.9	21	3.8	16	2.9
• National Gender Equality Policy – 2077 MoWCSC	-	-	7	2.5	-	-
Disaster Risk Reduction	**n= 46**	**2.5**	**n=41**	**2.6**	**n=13**	**2.3**
• National Policy for Disaster Risk Reduction – 2018 MoHA	2	2	3	2	1	2
• DRR National Strategic Plan of Action 2018 – 2030 (2018) – MoHA	22	2.9	26	3	4	3
• Disaster Risk Reduction and Management Act, 2074 & Rules - 2076 MoHA	2	1.5	2	1.5	2	4
• DRR Act 2075, Palungtar Municipality	4	2.3	5	2	3	1
• DRR Act 2075, Marsyangdi Rural Municipality	4	2	5	2	3	1
• Disability Related Ten Year National Policy & Plan (2073 – 2082) - DRR	12	2	-	-	-	-

MoHP: Ministry of Health and Population; MoHA: Ministry of Home Affairs; MoWCSC: Ministry of Women, Children and Senior Citizens

Table 5 shows the sum of frequency counts of disability, gender, and vulnerable groups (universal) commonly mentioned in the reviewed policy documents and their proportion across the 21 EquiFrame concepts. In aggregate, the vulnerable group – disability, gender, and commonly mentioned vulnerable groups - counted 286, 120, and 50, respectively. Altogether, the disability concept covered all 21 Core Concepts mentioned by EquiFrame with a 43% quality score, while gender and commonly mentioned vulnerable group concepts covered 81% and 62%, with 62% and 29% quality scores respectively. The core concepts of "Access" followed by "Non-discrimination" and "Individualised Services" were counted for all categories, while "Liberty" and "Family support" were counted the least.

Table 5: Proportion of References and Average Scores across Concepts in the Policy Documents

#	Concepts	Disability (n=286)		Gender (n=120)		Universal (n=50)	
		% Ref	Av. Score	% Ref	Av. Score	% Ref	Av. Score
1	Non-discrimination	5.9	1.7	14.2	2.3	14.0	1.3
2	Individualised Services	7.7	2.5	16.7	3.1	2.0	1.0
3	Entitlement	3.1	2.8	-	-	-	-
4	Capability- based Services	1.7	2.2	2.5	3.5	2.0	2.0
5	Participation	5.9	3.3	8.3	3.0	6.0	2.0
6	Coordination of Services	7.3	3.2	5.8	3.1	4.0	4.0
7	Protection from Harm	5.9	2.9	14.2	3.2	6.0	3.3
8	Liberty	1.7	2.5	-	-	-	-
9	Autonomy	0.7	2.0	0.8	4.0	2.0	4.0
10	Privacy	0.3	4.0	0.8	4.0	6.0	1.5
11	Integration	5.9	2.2	1.7	4.0	6.0	3.5
12	Contribution	1.4	1.5	0.8	1.0	-	-
13	Family Resource	2.4	3.0	0.8	2.0	-	-
14	Family Support	1.4	3.5	-	-	-	-
15	Cultural Responsiveness	2.4	1.4	0.8	4.0	-	-
16	Accountability	4.9	3.5	4.2	3.7	6.0	3.0
17	Prevention	5.9	3.4	9.2	2.5	-	-
18	Capacity Building	5.9	3.8	-	-	-	-
19	Access	19.2	3.2	15.8	3.2	28.0	2.9
20	Quality	6.3	2.1	1.7	4.0	16.0	1.7
21	Efficiency	3.5	2.8	1.7	3.0	2.0	3.0
		100	**43***	**100**	**62***	**100**	**29***

*N(3+4)/21x100

Table 6 illustrates marked differences in Core Concepts coverage and quality ranking between the policy documents. While analysing the Core Concept coverage by policies, Health policies in aggregate covered the highest proportion (52%) and the other policies – disability, gender and DRR - covered 46% aggregate in each. The overall summary rating was low in all policy documents with the highest rank in gender policies (28) followed by disability (22) and health (13). DRR policies ranked the least (8) in the composite quality index.

Table 6: Core Concepts Coverage and Composite Quality by Policies

Sectors	% Core Concept coverage			Overall Coverage	% Core Concept rated			Overall rating
	Disability	Gender	Universal		Disability	Gender	Universal	
Health Policies	**71**	**48**	**38**	**52**	**17**	**14**	**7**	**13**
• National Health Policy – 2019	14	24	33	24	5	14	14	11
• Public Health Service Act - 2077	10	10	-	10	10	10	-	10
• National Strategy for Reaching the Unreached – 2073 (MoHP)	71	33	-	52	52	33	-	43
• Gandaki Province Health Policy - 2078	29	19	19	22	0	0	0	0
Disability Policies	**95**	**33**	**10**	**46**	**48**	**16**	**3**	**22**
• National Guidelines for Disability Inclusive Health Services - 2019	86	19	-	50	29	19	-	24
• Disability Related Ten Year National Policy and Plan (2073 – 2082)	81	33	5	40	71	24	0	32
• The Act Relating to Rights of Persons with Disabilities - 2074 (2017)	67	5	5	26	43	5	5	18
Gender Policies	**48**	**52**	**38**	**46**	**33**	**27**	**24**	**28**
• Gender Equality & Social Inclusion Strategy of Health Sector 2018(MoHP)	48	48	38	45	33	43	24	33
• National Gender Equality Policy – 2077 (MoWCSC)	◎	29	-	29	-	10	-	10
Disaster Risk Reduction	**52**	**48**	**38**	**46**	**8**	**10**	**5**	**8**
• National Policy for Disaster Risk Reduction – 2018 (MoHA)	10	10	5	8	0	0	0	0
• DRR National Strategic Plan of Action 2018 – 2030 (2018) - MoHA	38	43	19	3	33	38	19	30
• Disaster Risk Reduction & Management Act 2074 & Rules 2076 (MoHA)	10	10	5	8	0	0	5	2
• DRR Act 2075, Palungtar Municipality	14	19	14	16	5	5	0	3
• DRR Act 2075, Marsyangdi Rural Municipality	14	14	14	14	5	5	0	3
• Disability Related Ten Year National Policy & Plan (2073 – 2082) DRR	33	-	-	33	5	-	-	5

DISCUSSION

While analysing the selected policy documents related to health, disability, gender, and DRR, the study found that the policies inadequately incorporated disability and gender issues in line with equity and human rights principles. It was also noted that the policies have not mentioned the Core Concept of disabilities and gender specifically, and most frequently they were mentioned in general and stated as "all people". This indicates that the policies provide limited guidance to include specific vulnerable groups such as persons with disabilities, and women and girls in the planning, system development and services. Moreover, they were all categorised as "low quality" as defined by the EquiFrame criteria. The mentioned concepts were poorly explained and the specific policy actions to address the concepts were barely stated. This finding is consistent with the shadow CRPD report submitted to the "Committee on the Rights of Person with Disabilities" in its 19th session by Nepalese organisations of persons with disabilities, which stated that disability has not been mainstreamed in many of the national health sector policies and plans (Autism Care Nepal Society (ACNS) et.al., 2018). Another study conducted using EquiFrame for the analysis of disability and gender inclusion in the Health, Water and Sanitation policies and strategies of Nepal reported similar results - that disability issues were inadequately covered within the policy documents (Wilbur et al, 2021). Policies in general emerge from government authorities or on their initiatives, and those policies related to gender and disability in particular are contingent upon national laws and international agreements which often are overlooked by omission or commission without proper analysis of potential consequences. Furthermore, a lack of political commitment to the promotion of disability and women's rights, and limited representation and participation of persons with disabilities and women in the policy process are commonly reported as the key reasons for policy insufficiency addressing disability and gender issues in the national policies and strategies (Bhandari, 2018; Nepal Disabled Women Association (NDWA), 2019; Wilbur et al, 2021).

Another important finding of this study is that the disability concept was better covered by the principles of equity and human rights in the policies, as compared to gender. The policies placed emphasis on access, individualised services and coordination of services for persons with disabilities, while the gender inclusion focussed on the individualised services followed by access, non-discrimination and protection from harm for women and girls. It can be explained that access,

non-discrimination, and protection have been getting priority in disability and gender advocacy over the past decades, and also these are the most commonly referred concepts in disability and gender-related international policy instruments including UNCRPD and CEDAW (United Nations, 2003, 2006). A number of core concepts appeared infrequently or were absent in the reviewed policy documents. For example, Autonomy and Privacy appeared the least in the policies for persons with disabilities. Liberty, Family Support and Capacity Building for women and girls were not mentioned in any policies included in the analysis.

The Constitution of Nepal 2015, Article 35, states that every citizen shall have the right to free basic health services and no one shall be deprived of emergency health care. It further states that each citizen shall have equal access to health care (GoN/MOLJPA, 2015). In line with the intent of the Constitution, eight sectoral ministries have developed their own gender equality and social inclusion (GESI) policies, and also the Local Government Operation Act (LGOA) 2017 has several provisions for promoting GESI (Asian Development Bank, 2020). Furthermore, Nepal has ratified more than 23 international human rights instruments that include international conventions and covenants on women, ethnic minorities, and persons with disabilities, and against racial discrimination (GoN/MoLJPA, 2018). Despite all these commitments, the policy provisions and legal mandates to improve gender equity and the inclusion of women and people with disabilities have been found to inadequately cover the basic elements of human rights principles in health, disability, gender and DRR policies. Nepal's prolonged political transition, lack of accountability of policymakers, and concentrated efforts and advocacy towards political representation indicate that little attention has been given to policy formulation. This has resulted in poor quality policies that may have ultimately impacted the fulfilment of the state commitments made at the national and international level.

This analysis revealed that the policies offered only weak protection for persons with disabilities and women/girls. However, the authors felt that it is not only a matter of the policies being consistent with human rights instruments such as UNCRPD, but the policies should also be directed to reducing the disproportionate impact that disasters have on vulnerable populations, e.g., persons with disabilities and women/girls in Nepal, which was not found in any of the policies analysed in this study. There is scope for further research on this important issue as this study has generated new findings by looking at national and local policies, thereby indicating a need for broader analysis. Assessment of

the national, provincial, and local level policies with a broader perspective in the respective sectors may allow further understanding of the complete scenario of gender and disability inclusion in the policies, their qualities and implementation status. Moreover, the findings of this study suggest that the key policies of related sectors need to be revisited in line with human rights approaches for the realisation of women and disability rights as committed by the state party.

Limitations

This policy analysis was a part of the study on "understanding the intersecting effect of gender, disability, and disaster meeting the healthcare needs and wellbeing of women with disabilities". Policies related to health, disability, gender, and DRR were selected but it was not possible to include all the policies (plan, strategies, acts, or legislations) in a single review; therefore, the complete picture of inclusion in the sectors may not be presented. Moreover, only two categories of vulnerable population/groups – persons with disabilities and women/girls - are included in the assessment and the large section of other vulnerable groups is excluded. Policy contents, structures, and statements in some documents were found to be very general and vague, sometimes creating difficulty to specify or count, and quality scoring. Furthermore, it is important to acknowledge that many of the concepts may have been referenced in the documents without specifying persons with disabilities, or women and girls. For example, concepts may have been included more broadly under the general all-encompassing language that applies to the entire population. Although information pertaining to these concepts should be covered for persons with disabilities, and women and girls specifically, there may be relevant information for these populations that may not have been captured while extracting the data from the documents. Another important limitation to be noted is that while EquiFrame identifies the commitment to social inclusion and human rights included in the policy documents, it does not, however, measure how effectively vulnerable groups are included in the mainstream policy works. Policy development, implementation, and evaluation are all equally important aspects to be assessed.

CONCLUSION

All the policies reviewed were varied but those policies have inadequately covered the core concepts and inclusion of disability and gender as defined in the EquiFrame. Almost all policies are relatively weak and ranked low in terms

of quality to address the health needs and rights of the vulnerable groups during disasters in particular. In order to enhance social inclusion and promote the rights and equity in healthcare through equitable policies, it is suggested that the human rights approach, as guided by the EquiFrame, be followed while developing policies in the future.

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