Support to the Safe Motherhood Programme

Strategic Issue Paper

Scaling Up Maternal and Neonatal Health Care in Nepal: How do we work towards national, sustainable provision?

January 2007

Summary

A sustainable health service is one that is guaranteed on an uninterrupted basis, even if it has to be financed from external sources. This is the only way that sustainability can be regarded in the context of a fragile state such as Nepal. Scaling up is not only about funding; it is also about the capacity to implement a major programme of development; to manage change; to deliver services and ensure that people can use them.

The Safe Motherhood Long-term Plan represents the lines of action needed to scale up services that are specifically for Safe Motherhood. In brief, these are to:
- scale up the size of the workforce
- conduct a programme of investment in infrastructural development
- take positive steps to improve physical assets management
- conduct a comprehensive programme of improvement of service delivery
- work to improve access to and utilisation of services

However, a series of vertical interventions in the field of MNH will not achieve the desired results. Calculations of the cost of achieving safe motherhood and newborn care, frequently ignore investment costs, costs related to demand-side activity, and of generic health system improvements needed to support the effectiveness of MNH interventions in real life.

The major challenges facing Nepal in scaling up MNH are: funding, pace at which infrastructural development can be carried out; need to tailor strategies according to geographical zone; need to maximise integration of concerns; pace at which health service management can be improved; lack of a referral system; fragile political environment; and technical capacity. The way forward for SSMP must depend on judgements about the required timeframes for real change.

What is scaling up?

Generally, 'scaling up' means translating one or more interventions or services that have been tried out successfully as a pilot (or found to be successful in other countries) into part of the national health care system.

Frequently, the prime focus is on finding financial resources to cover the cost of such an expansion. Until recently there was a tendency in development aid circles to assume that the desirable and sustainable approach to scaling up, was to persuade developing country governments to recognise the need for this to happen and to find their own resources to make it possible. Nowadays, it is generally acknowledged that many countries will need massive support if they are, for example, to even come near to achieving the MDGs. A sustainable health service is one that is guaranteed on an uninterrupted basis, even if it has to be financed from external sources. This is the only way that sustainability can be regarded in the context of a fragile state such as Nepal[1]

Much preoccupation with scaling up within DfID and doubtless other bilateral donor agencies of late, relates to the global efforts to expand official development assistance flows, through the UN Millenium Project and Summit, the Commission for Africa, the G8 and EU summits with extended multilateral relief and a possible International Finance Facility. Global aid is said to be likely to reach US$100-150bn per annum by 2010 – 2015. The DfID White Paper 2006, talks of aiming for at least half of all future UK direct support for developing countries to target public services (water, health, education and social protection), and agreeing ten year commitments with developing countries to do this.

DfID's first progress report on its Maternal Health Strategy (Dec 2005 #4.1) states as a challenge for DfID: "Finances for scaling-up – encouraging all donors to commit to the long term predictable financing that is vital for scaling up investment in maternal and other health services. Although advocacy is working, DfID, donors and governments need to recognise that the overall budget for the health sector and for maternal health remains very low and in some cases per capita spend is actually falling."[2]

However, it must be recognised that scaling up is not only about funding; it is also about the capacity to implement a major programme of development; to manage change; to deliver services and ensure that people can use them.

What would it mean to scale up MNH services in Nepal?

The Safe Motherhood Long-term Plan represents the efforts of a large group of stakeholders from government and its partners, to lay down the lines of action needed to scale up services that are specifically for Safe Motherhood. In brief, the main areas of development are to:

- scale up the size of the workforce
- conduct a programme of investment in infrastructural development
- take positive steps to improve physical assets management
- conduct a comprehensive programme of improvement of service delivery

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[1]. Pavignani E & Colombo A, WHO Module 6: Analysing Health Sector Financing and Expenditure
[2] DfID Maternal Health Strategy *DfID Reducing Maternal Deaths: Evidence and Action* First Progress Report, December 2005, p10.

- work to improve access to and utilisation of services

However, as is argued below, such a programme is not to be considered lightly; nor will a series of vertical interventions in the field of MNH achieve the desired results. To quote the original DfID strategy paper:

> "New approaches to development assistance offer potential for more sustained approaches to maternal mortality reduction. Sector – wide approaches (SWAps) can reduce or eliminate the distortions created by vertical or fragmented approaches. They provide a framework for donors and government to strengthen health systems while focusing on maternal mortality reduction as an indicator of progress. Reduction in maternal mortality rates should be a key part of sector plans……..
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> In short, maternal mortality can be considered the best single indicator of the effectiveness of a country's health system."[3]

Such assertions have major implications for the way in which we look at scaling up maternal and newborn care (MNH), and its costs. One way of counting the cost, is to simply consider the costs of those interventions directly related to MNH – in other words, antenatal care, treatment of complications during pregnancy, skilled birth attendance, emergency obstetric care, and postpartum care. Such a calculation, taking the estimates from the 2005 World Health Report would give an estimate of $0.22 to $1.18 per head, whereas taking the 2001 estimates of the Commission for Macroeconomics and Health would give an estimate of $0.36 - $0.58, increasing to $0.89 - $$2.40 in 2015[4]. A similar set of calculations have recently been undertaken by UNDP in Nepal, which offers a per capita cost of NRs39.8 at current prices. These calculations are included in Annex 1.

The problem with such calculations is (a) that they do not necessarily include investment costs, (b) they do not include any costs related to demand-side activity[5] and (c) they do not include the cost of health system improvements that will be required to support the effectiveness of the MNH interventions in real life. If we take seriously the actual achievement of MNH as being dependent on a functional, integrated health care system, we cannot pull out the costs of specific interventions and pretend that that scale of investment will bring us maternal and newborn health.

Finally, many such calculations are done on the basis of average cost rather than marginal cost. In a country like Nepal, the rise in marginal costs as one attempts to do something about health services in the more remote areas, is bound to be prohibitive.

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[3] DfID Reducing Maternal Deaths: Evidence and Action, A strategy for DfID, Sept. 2004, paras 61 & 63.

[4] Borghi J, Ensor T, Somanathan A, Lissner C, & Mills A, 2006,'Mobilising financial resources for maternal health' *Lancet*, published online September 28.

[5] The UNDP study in Nepal claims to cover the demand side costs of maternal health services, but the package described has no specific demand side activity.

What are the major challenges facing Nepal in scaling up MNH?

Funding

However we count the cost of scaling up, there is a major issue about the sources of the required funding. It is a fact that the Government of Nepal spends much less even than most developing countries on health care (currently only 6.5% of government expenditure), and spends only about half as much on health as on education. According to WHO estimates, the total national health expenditure for 2000 as a proportion of the GDP was 5.4%[6.] There is need for advocacy both towards government and donor partners, to both increase health expenditure and to give long-term commitments.

It was suggested earlier that there is, first and foremost, a need for advocacy for safe motherhood and newborn care and for funding to make this possible. As we have seen, this implies both funding directly for, for example, emergency obstetric care facilities, and also funding for more generic areas of health sector reform. Advocacy is required to convince all parties that health is a priority, not only as an integral tool in the fight against poverty, but also as a right and as something greatly valued by citizens.

At the same time, while documents such as the NHSP-IP implicitly recognise the importance of safe motherhood and newborn care by making maternal mortality a key indicator, it is important to constantly remind decision makers of this. The arguments are extremely strong; as well as saving lives of mother and newborn, every maternal life saved results in a reduction in the chances of other children in the family dying, by 3 – 10 times.[7]

Need for major commitment to achieving required numbers of skilled birth attendants

Training is an area that is absolutely vital in relation to MNH, as the implementation of the government's policy on Skilled Birth Attendance relies on a major increase in the number of cadres who meet the criteria defining Skilled Birth Attendants (SBA). There is a need for a radical look at what resources this will take, both in terms of the number and quality of training sites, the teachers/ trainers required, and the stipends for a greatly increased number of students. To be realistic about training requirements, it is probably time to stop hoping that the issue of brain-drain will go away. A proportion of all staff trained to SBA level will be attracted out of the government sector and into private sector jobs within Nepal. The private sector plays a significant role in health service provision in Nepal, and human resources are needed to support this. Staff in the better-qualified positions are tempted by overseas opportunities, and the annual outward migration of some of the limited numbers of nurses and midwives will continue. In planning for human resources development, it is probably necessary to take account of this in estimating needs.

To meet the challenge of production of adequate numbers of Skilled Birth Attendants, it will be necessary both for government to become serious about a major shift in attitude towards training, and for external donor partners to make a major commitment in agreeing to a strategy

[6] WHO SERO 2000. Financial resources for health http://www.searo.who.int/EN/Section313/Section1523_6865.htm

[7] Lawn JE, Coussens S, Bhutta ZA et al., 2004, 'Why are 4 million newborn babies dying each year?' **Lancet 364**, 399-401.

for supporting training as a collaborative endeavour. The SSMP core team are currently giving priority to ensuring that coordination is achieved in relation to the various training and related inputs needed to upgrade existing health workers to SBA standard, as the first major step forward.

In addition to human resource development, attention must be given to both creating terms and conditions of employment that are attractive to staff as well as an enabling working environment. These are major challenges, not only for those concerned with MNH services, but for the system as a whole. The SSMP core team have recently undertaken work to identify the human resource management issues that are to be seen as critical in retention of skilled birth attendants; it is hoped that there can be dialogue with those involved in generic health sector reform issues in order to advocate for action.

Pace at which infrastructural development can be carried out

The improvement of and addition to existing infrastructure is an essential component of achieving good MNH services. Indeed, a crucial consideration in developing effective plans for scaling up, will be the pace at which infrastructural improvements can take place; this combined with the speed at which SBA training can be conducted, will dictate a maximum speed for other developments. Related issues concerning infrastructure planning are being dealt with in another paper in this series.

Need to tailor strategies according to geographical zone

In a country with terrain as varied as that of Nepal, it would be difficult to imagine that any one formula for health service functioning, or for distribution of services and facilities, would work country- wide. Furthermore, any attempt to provide the same services in the mountains, hills and terai, would mean that some facilities would only be built and run at an extremely high cost.

SSMP prefers to explore alternative solutions for the more inaccessible parts of the country. Thus for example, it has just been agreed that UNICEF will experiment with an arrangement for Humla, whereby expectant mothers about to give birth, can if necessary be airlifted out and brought to emergency obstetric care, rather than trying to implement EOC in such a distant and under-populated part of the country, where many inhabitants themselves migrate to more hospitable climes during winter.

In maximising efforts to distribute resources in an equitable fashion, SSMP would welcome participation in a wider debate within the Ministry of Health and Population on the subject of inter-district equity. A clear policy on these issues is presently lacking, and it is inappropriate to develop policy only in relation to maternal and newborn care, when a coherent approach is needed across the board.

The need to maximise integration of concerns

SSMP has supported the development of the revised Safe Motherhood Plan, taking into account the need to integrate work in the areas of safe motherhood, newborn care, and comprehensive abortion care. Scaling up can be supported significantly if resources available for these related areas can be allocated within an integrated strategic planning framework. Work has already been undertaken to explore the possible synergies from integrating safe motherhood and newborn care with the national programme to combat HIV/AIDS.

Other potential synergies should be explored and encouraged. This is one way in which the marginal costs of specific activities can be reduced. For example, if it is possible for the HIV/AIDS managers to agree with safe motherhood protagonists as to district selection each year for on the one hand, opening up HIV/AIDS-related work, and on the other developing EOC, it is possible that costs of ensuring safe blood, for instance, and safe laboratory and surgical conditions, can be shared.

The pace at which health service management can be improved

This is one area in which it is crucial that those advocating for safe motherhood and newborn care recognise and advocate for generic improvements across the health service. It is possible to make some minor improvements in the way that, say, maternity records are kept or a new scheme such as the maternal incentives scheme is managed, but the majority of management concerns will affect the way in which a facility is run in geneal. SSMP is able to support the Department of Health Services in some key areas such as infrastructural development, logistics and physical assets management. However, generic improvement in health service management and management systems must depend on the health sector reform process.

Strategies for improving management systems will need to be worked out in the context of the decentralisation process, and at this point in Nepal's political history, it is difficult to forecast when – or even if – local government and devolution of decision making over health care will become a reality. In the short term, it may be preferable to assess what functions can be deconcentrated within a non-devolved system. SSMP and the safe motherhood and newborn care community in general, cannot affect decentralisation, but it is necessary to ensure that the decentralisation process works in favour of health care and not the reverse. This will involve ensuring adequate management capacity at district level, twinned with clarity about the rights of patients and effective community structures for participation in decision making. When local governments are in place, there will be need to educate elected members about the importance of maternal and newborn care, as well as delineating what responsibilities they should carry in relation to health services (duty to complain when staff desert their post or are rude, but not making technical judgements, which must be left to professionals, for example).

Lack of a referral system

A functional referral system is another major need for effective safe motherhood and newborn care, and certainly one not included in narrow estimations of cost. The terrain, and lack of transport infrastructure once again creates a major challenge that in no way can be underestimated.

The fragile political environment

Although these are days of hope for Nepal, it would be irresponsible to ignore the fact that there are many uncertainties in the period ahead, and many dissident groups. This may have disruptive consequences in terms of district work. At the same time, as the peace between Maoists and the seven-party alliance holds, and people begin to return from district centres to their homes, it may become harder for them to seek health care than has been the case in recent times.

Not only does the unknown political future throw up question-marks about working in districts, it implies uncertainty about future health policy. For example, there are currently moves to make

at least primary health care free of charge. Different ruling parties in the post – general election period, may have considerably differing views over health sector reform issues such as contracting, relation to private for-profit providers and other potential partners in any aspect of health care work.

Technical capacity

Presently, SSMP is implementing work to improve service delivery through a range of partners. This creates a larger pool of technical expertise for supporting districts in improving their services than would be the case if all work were done through government. There are however, queries about the feasibility of this arrangement for the future.

One question is how organisations capable of contributing to safe motherhood and newborn care can in future be contracted. Firstly, there may be bureaucratic obstacles if not actual regulations against such contracting (possibly depending on the nature of the organisation to be contracted). Secondly, it is clear that the Ministry has very little capacity for contracting; its efforts to recruit short term consultants in relation to health sector reform issues has, for example, largely failed.

There are similar questions about how the equity and access work initiated under SSMP will be taken forward. Presently, this work is supported via a contract between SSMP/Options and ActionAid Nepal, the latter, as an international NGO, acting as an Equity and Access Agency. In turn AAN contracts national NGOs that have a presence in the districts prioritised for equity and access work, to further such concerns in those districts. Additionally, an independent agency has been contracted to monitor community voice in these districts, as a way of monitoring the impact of the work of the NGOs.

As has been described in a companion note about contracting (see Annex 2), it is presently extremely difficult to see how this work can be taken forward by government. There are administrative and other barriers to the practicalities, and there is virtually no expertise in MoHP to support demand-side work. Moreover there are many who would argue that there are aspects of such work that are not best performed by government, but in fact need the support of independent, non-government supporters of civil society. The voice monitoring, at a minimum, must be seen to be independent.

It is significant that the amount of effort that was needed for SSMP (even without any government restrictions directly in its path) to contract partners and come to a clear understanding of what was wanted in each contractual arrangement was probably much greater than had been expected. The first twelve months of the programme was close to an end before most partners were ready to sign a contract or MOU, and it took the first half of the following year for partners in general to settle into the work, recruit staff and develop a clear programme of activity. The SSMP team are of the view that these agreements need to be extended for a substantially longer duration if the anticipated benefits are to be reaped.

It is difficult at the present time to forecast what can be achieved through working with various different partners, but the low capacity of the health system is a powerful stimulant in terms of making every effort to use private (for profit and not-for-profit) partners. In current international debates about scaling up, there are conflicting views and judgements about the most appropriate strategies in fragile states with weak capacity in government. One side argue that all resources should be directed at strengthening government capacity in the interests of long-term

sustainability; the other that supporting and maximising the use of partners is the only way to achieve impact in the short or indeed medium term, and investment must be made in the use of partners, even if the transaction costs are high.

In the case of Nepal, the lack of capacity in government services is so extreme that a dual-pronged approach seems the only way forward. However, as noted above, it will be necessary to create the capacity and conditions within which sustainable partnerships can be forged and sustained.

Annex 1

Low cost scenario - Estimated cost on maternal health for scaling up (based on UNDP cost estimate)					
Descriptions	2006	2007	2008	2009	2010
Per capita cost in NRs as estimated by UNDP Nepal in 2006 (excluding personnel cost, training, and infrastructure development)	39.8	45.6	51.4	57.2	63
Population in million	25.887	26.451	27.015	27.577	28.136
Required cost in NRs million	1030.30	1206.18	1388.56	1577.38	1772.60
Expected funding in NRs million	420	504.000	604.800	725.760	870.912
Gap in NRs million	-610.30	-702.18	-783.76	-851.62	-901.69
Gap in US$ million	-8.48	-9.75	-10.89	-11.83	-12.52
-Per capita cost for years estimated on the basis of costing done by UNDP2006 - Estimate of expected expenditure calculated with 20% growth - Medium population growth applied					

High cost scenario- Estimated cost on maternal health for scaling up (based on Macroeconomics and Health)					
Descriptions	**2006**	**2007**	**2008**	**2009**	**2010**
Per capita cost in NRs as estimated by Macro economics and Health	102.9	110.7	118.4	126.2	134.0
Population in million	25.9	26.5	27.0	27.6	28.1
Required cost in NRs million	2664.0	2927.5	3199.6	3480.3	3769.5
Expected funding in NRs million (including human resource and infrastructure development)	815.5	978.6	1174.3	1409.1	1690.9
Funding gap in NRs million	**-1848.5**	**-1948.9**	**-2025.4**	**-2071.2**	**-2078.5**
Funding gap in US$ million	**-25.7**	**-27.1**	**-28.1**	**-28.8**	**-28.9**
Existing per capita expenditure in NRS	**31.5**	**37.0**	**43.5**	**51.1**	**60.1**
Per capita funding gap in NRs	**-71.4**	**-73.7**	**-75.0**	**-75.1**	**-73.9**
-Per capita cost for years estimated on the basis of costing done by Macroeconomics and Health -Estimate of expected expenditure calculated with 20% growth - Medium population growth applied					

Argument on costing

The above cost estimates have been done considering demographic, behavioral and epidemiological data. The costs of expanding services were prepared on the basis of scaling up plan and population growth. The costs of expanding services will vary by region to region based on the level of investment and ability to expand services.

The costing exercise has been done assuming the normal topography and infrastructure, in case of Nepal where infrastructure is poor and populations are scattered in the mountain and high hill, the cost will go up. For example, a BEOC and a CEOC facility may not cover the defined population, therefore needs additional.

The transportation cost of drugs/equipment goods and services and construction materials therefore costs of SMNH package increase substantially. The wage rate also increases with the increase of altitude. Therefore, costs would be higher in case of Nepal.

In case of Nepal, the demand side costs such as awareness creation and transport would be higher due to the introduction of maternity incentives scheme. This type of scheme has not been included in the costing exercise. Furthermore, no generic health systems improvements are included in these costings.

With the above arguments, and the figures obtained from different estimation, it can be stated that these are extreme underestimates of the real cost of achieving safe motherhood and newborn care in Nepal.

Annex 2

Contracting and partnership agreements: the SSMP experience

The first part of the JAR A-M refers to the need to supplement the technical and implementation capacity of the Ministry of Health and Population by contracting NGOs and the private sector to help scale up service delivery models. In fact, SSMP has pioneered work in this area, and has contracts or memoranda of understanding with several different partners who are all undertaking the work of SSMP with funding from the programme. It is a pity that the JAR A-M failed to take account of this, and demonstrates the need to continue to strive to ensure that work on an area like safe motherhood is seen as mainstream MOHP work, not a sideline or vertical programme.

The work undertaken by SSMP needs to be taken as valuable experience in the field of contracting out. Several areas of study are required;

(1) The SSMP team found that the transaction costs of setting up the contracts were high – higher than expected, and the whole process was lengthy. This merits further review to analyse if the costs could have been reduced, if the experience gained can be capitalised upon in order to reduce costs and increase the efficiency of future transactions, and what capacity building would be required within the MOHP to take over this activity.
(2) The contracts / MOUs have mainly been in place for less than one year up to now. It will be valuable to evaluate how effective they turn out to be as instruments for increasing / improving service delivery or other areas of work.
(3) In some areas of work (notably, that of monitoring the voice of local communities in relation to health care) contracts allow an activity that government cannot undertake for itself; this needs to be duly noted. However, important questions about the sustainability of all these agreements need to be addressed urgently – and this is important before new contracts are considered. These are around the issue of how the agreements can be sustained. One simple possibility would be for DfID to agree to extend its funding of these on a much longer time – frame (in order for organisations involved in improving service delivery currently in ten districts, to be able to move on over time to other districts for example). Another possibility would be to examine how government can contract directly and with what types of partner – as well as asking what partners will be willing to contract with government.

Systematic study of these issues has not been undertaken, and it could be that, if there is to be ownership of the results of such work, that there should be participation in the work from the policy level of MoHP. The comments below are based on the reflections of those SSMP core team members who were in post at the stage of setting up contracts and MOUs with the various partners in SSMP. As such, they raise important questions for future programming.

Transaction Costs

'Cost' in this context is taken to mean time and effort on the part of the SSMP core team as well as for the partners involved.

In general, the SSMP team were surprised at the length of time the contracting / agreements process took. Contributory factors included:

- Time required to identify potential organisations in Nepal, and to evaluate the need for conducting a limited tender, or merely to invite selected organisations to submit proposals for the work; this required assessing capacity in the various organisations around

- Need to develop clear definitions of the work required and develop judgements within the SSMP core team about what this should cost. In the case of the equity and access work, this also called for the development of a new conceptual framework and this itself took time.

- Need to develop an understanding in government as to the value of such contracts and agreement with the scope of work involved – complicated by frequent staff changes.

- Time and effort required in order to identify meeting places between different organisational cultures and practices; each of the SSMP partners is radically different in terms of the contractual requirements and practices of their parent organisation. This includes among other areas, different budgetary practice, different expectations about profit margins/ overhead levels, staffing regulations, practice concerning 'brand-labelling' of partner activities, need for technical support from SSMP, ability to work with government and different conceptual starting points with regard to safe motherhood.

The bullet points above refer to the time and effort taken to put contracts and agreements in place with the various partners. Of course, following this, the partners have then needed time in order to recruit staff, develop detailed work plans and logical frameworks, and put working arrangements in place. The SSMP core team have been drawn into much more, and more sustained, technical support than was anticipated, and this is an ongoing need. We suspect that all parties have been surprised at how long the set-up period in total has been, and it is worth considering conducting some study and debate – involving all partners and DfID – as to the efficiency and efficacy of the process.

Has it been worthwhile?

It is early days in terms of the partners' work – too early to attempt an evaluation of the type proposed above.

The SSMP core team, when asked this question, offered several kinds of answers. First was the response that, if SSMP had been allowed to follow a project approach, to get on and recruit staff to support district work and to have managed this work directly, it would have been considerably faster, more efficient and given good results at considerably lower cost (by reducing the management costs of having to work through other organisations and contribute to their overheads). Furthermore this approach would have been acceptable to many government people, who are interested often in quick wins and not that keen to invest in long-term capacity building (given their own high level of professional mobility).

Second was a response valuing process, whereas the above comments value results over process. Most of the team feel highly positive about the extent to which bonding within the group of SSMP partners is providing a learning experience for all concerned, and creating a forum where ideas about how to do safe motherhood and newborn care can be refined, lessons noted and shared.

If the latter experience is to be truly valued, it will be important to see how the learning can extend beyond the limited group of individuals representing the partners at regular meetings, and in particular how such learning can translate into government policy and practice.

Can it be sustained?

The feeling of the SSMP core team is that the effort and cost involved in setting up the present set of partner agreements, was in line with what was a realistic requirement for such a complex set of arrangements. Given the low level of capacity in government services in Nepal, any alternative approach would have had to face, head-on, the need to increase the number of professionals supporting safe motherhood at all levels – a Herculean task. However, the first phase of SSMP has only allowed the team to begin to develop a meaningful strategy for substantially increasing the supply of skilled birth attendants – and this is just one category among others that are needed.

If the impetus created through the work of partners is to pay off in terms of direct improvements in the districts where they presently work, and to allow for the systematic improvement of other districts, then the present contracts and agreements will need to be extended. In the longer term, a two-pronged approach is probably necessary whereby government capacity is increased on the one hand, and study of means of supporting a pluralistic approach to maternity and newborn care provision can be made a reality, simultaneously takes place.