



# Support to the Safe Motherhood Programme in Nepal: An Integrated Approach

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**Abstract:** Evidence gathered from 1997 to 2006 indicates progress in reducing maternal mortality in Nepal, but public health services are still constrained by resource and staff shortages, especially in rural areas. The five-year Support to the Safe Motherhood Programme builds on the experience of the Nepal Safer Motherhood Project (1997–2004). It is working with the Government of Nepal to build capacity to institute a minimum package of essential maternity services, linking evidence-based policy development with health system strengthening. It has supported long-term planning, working towards skilled attendance at every birth, safe blood supplies, staff training, building management capacity, improving monitoring systems and use of process indicators, promoting dialogue between women and providers on quality of care, and increasing equity and access at district level. An incentives scheme finances transport costs to a health facility for all pregnant women and incentives to health workers attending deliveries, with free services and subsidies to facilities in the poorest 25 districts. Despite bureaucracy, frequent transfer of key government staff and political instability, there has been progress in policy development, and public health sector expenditure has increased. For the future, a human resources strategy with career paths that encourage skilled staff to stay in the government service is key.

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**S**UPPORT to the Safe Motherhood Programme (SSMP), funded by the British Department for International Development (DFID) and managed by Options UK, was initiated in 2004 as a five-year agreement with the Government of Nepal. It is designed to support the national Safe Motherhood Programme and complement the DFID Health Sector Reform Support Programme. SSMP builds on experiences from the Nepal Safer Motherhood Project (1997–2004) but differs significantly, moving from a district-focused project to a programme approach, work-

ing directly with and through the government to build capacity and develop systems, based on the national goals and logical framework. Inputs are designed in collaboration with the Ministry of Health and Population in order to ensure they meet national needs. Financial aid is paid directly to the government, with technical assistance provided through a core team of centrally-based advisers and five implementing partners responsible for focused activities in selected districts, which feed into central planning and advocacy.

57 The 2006 Nepal Demographic and Health  
58 Survey<sup>1</sup> showed a reduction in the maternal  
59 mortality ratio from 539 per 100,000 live births  
60 in 1997<sup>2</sup> to 281. This has provided a tremen-  
61 dous boost to the national Safe Motherhood  
62 Programme and partners. Since its inception in  
63 1997, the national Programme has focused on  
64 improving the availability, quality and utilisation  
65 of emergency obstetric care in district hos-  
66 pitals, to address the needs of the estimated 15%  
67 of pregnancies likely to develop serious compli-  
68 cations,<sup>3</sup> which account for 70% of maternal  
69 deaths in Nepal.<sup>5</sup> A range of external agencies  
70 have supported staff training, infrastructure  
71 and equipment, behaviour change interventions  
72 promoting antenatal, skilled delivery and post-  
73 partum care, and community emergency funds  
74 and transport schemes. As a result, between 1996  
75 and 2006, utilisation of antenatal care services  
76 increased from 39% to 72%, delivery by a trained  
77 health worker from 9% to 19%, institutional  
78 delivery from 8% to 18% and caesarean sections  
79 from 1% to 2.7%.<sup>1</sup> Abortion was legalised in 2002  
80 and safe services (public, private and NGO) are  
81 now available in 70 of the 75 districts, with over  
82 80,000 women accessing them between April  
83 2004 and December 2006. This has reduced the  
84 risk of deaths due to unsafe abortions, although  
85 it is still too early to see a significant effect on  
86 the figures. Perhaps most importantly of all, the  
87 lifetime risk of maternal death declined by 33%  
88 between 1996 and 2006, as the total fertility rate  
89 declined from 4.6 to 3.1.<sup>1</sup> Further analysis has  
90 been commissioned on some of these key issues.

91 Despite this encouraging progress, public health  
92 services are still constrained by resource and staff  
93 shortages, especially in rural areas, where 83% of  
94 the population live.<sup>5</sup> A recent survey undertaken  
95 by UNICEF in eight SSMP/UNICEF-supported dis-  
96 tricts showed staffing levels of posts for doctors  
97 and nurses of only 50–60% as the norm, even in  
98 district hospitals, with the situation considerably  
99 worse in peripheral facilities.<sup>6</sup> Services are often  
100 perceived to be of poor quality and do not meet  
101 women's needs, as evidenced in a recent study  
102 by the Save the Children US Access programme,<sup>7</sup>  
103 which found that women were not utilising ser-  
104 vices for this reason, preferring a home birth  
105 except in extreme emergencies. Lack of know-  
106 ledge and finance are also significant barriers  
107 to accessing services, especially among poor and  
108 socially excluded families, and pro-poor target-

ing of demand creation is essential to ensure that  
improved services do not benefit only the better  
off and those living close to facilities.

## An integrated package of support

Efforts to improve emergency obstetric care have  
been increasingly complemented by involvement  
of communities and local NGOs in promoting  
access to and demand for services, and a focus on  
social inclusion to reach marginalised commu-  
nities. Promotion of delivery by skilled birth  
attendant, rather than health worker, is another  
important development. Perhaps most signifi-  
cant has been recognition of the importance of a  
functioning overall health system to support safe  
motherhood efforts. This is reflected in SSMP's  
close links with the DFID Health Sector Reform  
Support Programme, through which SSMP can  
act as a pilot and an indicator for whole sector  
approaches,<sup>8</sup> and health sector reform efforts can  
support safe motherhood programming through  
critical areas such as human resource management.

Support to the Safe Motherhood Programme  
provides an integrated package of technical sup-  
port in six key areas:

- policy development and planning,
- service strengthening, including infrastructure,  
technical and management improvements,
- human resources development, particularly  
for skilled birth attendants,
- increasing equity and access,
- financing demand creation, and
- monitoring and information management.

## Policy development

SSMP is working with other safe motherhood  
stakeholders to support significant policy and  
planning developments as a foundation to the  
national programme:

- Development of the revised National Safe  
Motherhood and Newborn Health Long-Term  
Plan, 2006–2017.<sup>9</sup>
- Revision of the National Blood Policy in 2006  
and work with the Nepal Red Cross Society  
and National Blood Laboratory to develop  
guidelines and provide training to ensure the  
availability of safe blood at district hospitals  
providing emergency obstetric care.<sup>10</sup>
- Support for the integration of abortion as an  
essential safe motherhood service under the

- 160 National Safe Abortion Policy, 2002<sup>11</sup> that legal-  
 161 ised abortion up to 12 weeks of pregnancy.
- 162 • The SSMP draft Social Inclusion Strategy<sup>12</sup>  
 163 is at final discussion stage and will be used  
 164 to influence health sector reform and gov-  
 165 ernment policy development. It reflects the  
 166 need to target the poor and excluded, as  
 167 recent data show that access to safe mother-  
 168 hood services is strongly affected by caste  
 169 and ethnicity. This strategy is timely as recent  
 170 political developments in Nepal place social  
 171 inclusion at the heart of a new national reform  
 172 agenda, challenging deeply rooted attitudes  
 173 and practices.
  - 174 • Development of the National Policy for Skilled  
 175 Birth Attendants 2006,<sup>13</sup> which embodies a  
 176 commitment to skilled attendance at every  
 177 birth, whether at home or in a facility.<sup>14</sup> Nepal  
 178 is one of the few developing countries to have  
 179 such a policy.
  - 180 • Preparation of a draft strategy for mainte-  
 181 nance of health infrastructures<sup>15</sup> to ensure  
 182 facilities are fit to provide quality services and  
 183 to reduce wastage.

### 185 Strengthening services

186 To improve the quality of obstetric care, the Nepal  
 187 government and partners have developed a mini-  
 188 mum package of essential maternal and newborn  
 189 health services to be provided at different health  
 190 facility levels, which meets the WHO criteria for  
 191 evidence-based care<sup>16,17</sup> and addresses the causes  
 192 of maternal death. The document specifies the  
 193 services, staffing and equipment expected at  
 194 each level of health facility and integrates new-  
 195 born care, safe abortion and prevention of mother-  
 196 to-child transmission of HIV with safe motherhood  
 197 services, optimising use of resources and provid-  
 198 ing a national standard.

199 SSMP is working with the government to  
 200 develop a cost-effective approach to improving  
 201 services in districts that do not have project sup-  
 202 port. Based on the "appreciative inquiry" tech-  
 203 niques used in the Nepal Safer Motherhood  
 204 Project districts,<sup>18</sup> this approach aims to empower  
 205 health facility management committees and com-  
 206 munities to take responsibility for improving local  
 207 services. It focuses on positive achievements rather  
 208 than gaps and failings, with the aim of creating  
 209 a belief in the power to change, and working with  
 210 participants to identify changes needed and ways  
 211 to achieve them. It has been successfully piloted

in one district and modalities for scaling it up are  
 being developed.

The pilot, Lahan hospital, serves a densely  
 populated plains district (population 569,880<sup>19</sup>),  
 with a large number of poor and disadvantaged  
 communities. As a busy referral centre for sev-  
 eral neighbouring districts, its essential obstetric  
 care facilities are being upgraded. However sig-  
 nificant gaps were noted in the quality of care  
 provided, such as poor infection prevention and  
 waste disposal practices, overcrowded service and  
 waiting areas with sub-optimal patient flow  
 arrangements, erratic staff attendance and emer-  
 gency drug supplies not maintained. As a result,  
 the reputation of the hospital and relations with  
 the local community were not good.

The process began with a needs assessment  
 in December 2005,<sup>19</sup> followed in May 2006 by  
 a planning workshop jointly organised by the  
 local health authority and facility management  
 committee. It was facilitated by a professional  
 experienced in appreciative inquiry, with tech-  
 nical inputs from SSMP and central government  
 staff. The technical sessions helped to increase  
 the understanding about maternal and newborn  
 health among management and community par-  
 ticipants and gain their support. Local partici-  
 pants included representatives from civil society,  
 political parties, local media, development pro-  
 grammes and health workers. They were guided  
 to use the findings of the needs assessment and  
 technical inputs to develop a six-month plan  
 for ensuring 24-hour quality obstetric care ser-  
 vices. This covered infrastructure, equipment,  
 staff training, management and community rela-  
 tions, with activities ranging from cleaning the  
 hospital surroundings and managing patient flow,  
 to renovating service rooms, improving waste  
 management and disposal systems, and estab-  
 lishing subsidy systems.

At a second review and planning workshop,  
 three months later, achievements were reviewed  
 and plans adjusted for the next phase, including  
 rolling out the process to peripheral facilities.  
 During the first year of the pilot, the package  
 has proved practical and flexible, facilitating  
 major positive changes, both tangible and less  
 tangible.<sup>20</sup> Some, such as improvements in sur-  
 gical facilities, were initiated immediately after  
 the needs assessment, stemming from the sense  
 that support was available. Later improvements  
 included better infection prevention and waste

264 disposal practices and improved overall clean-  
 265 liness, regularly maintained supplies of emergency  
 266 drugs and equipment, use of the partograph and  
 267 improved layout of the labour room for privacy.  
 268 Human resource management has improved and  
 269 the hospital management committee recruited  
 270 additional staff from its own budget. Patient  
 271 flow and social relations have improved, with a  
 272 new layout of the reception area and the recep-  
 273 tionist making patients feel more welcome.  
 274 Subsidies and free services are available for the  
 275 poor. As a result, hospital records show a sig-  
 276 nificant increase in service utilisation, as shown  
 277 in Table 1.

278 Having broken out of a cycle of poor services,  
 279 poor reputation and low utilisation, the hospital  
 280 has more women using services, more support  
 281 from the community, better management and  
 282 higher staff morale, enabling it to continue to  
 283 improve, with only minimal external inputs from  
 284 regionally based monitoring and support staff.

285 A small team of consultants, led by the pilot  
 286 facilitator with support from the government  
 287 and SSMP, has begun implementing the pack-  
 288 age in a further 13 facilities in seven districts.  
 289 These were prioritised to complement the demand  
 290 creation inputs of the SSMP equity and access  
 291 programme in these districts. In the next phase,  
 292 emergency obstetric care facilities receiving sup-  
 293 port for new buildings or significant renovations  
 294 will be targeted to enable them to maximise these  
 295 inputs to improve services.

### 296 Skilled birth attendance

297 Increasing skilled attendance at birth is an  
 298 essential component of safe motherhood pro-  
 299 gramming.<sup>14</sup> In Nepal it has been agreed that a

300 doctor, nurse or auxiliary nurse-midwife who  
 301 has received standard training in the interna-  
 302 tionally defined set of core midwifery skills<sup>21</sup>  
 303 qualifies as a skilled birth attendant. In the drive  
 304 to achieve the Millennium Development Goal  
 305 of reducing maternal mortality by three quarters  
 306 by 2015, Nepal has set the target of 60% of all  
 307 births assisted by a skilled birth attendant.<sup>22</sup> In  
 308 reality, this is probably an unreachable goal,  
 309 involving the in-service training of over 4,000  
 310 staff in less than five years and revision of pre-  
 311 service courses. Key issues are the shortage of  
 312 health staff, especially in rural areas, and low ser-  
 313 vice utilisation. Currently only 23.4% of births  
 314 are attended by any kind of health worker,<sup>23</sup>  
 315 and not all health workers can qualify as skilled  
 316 birth attendants.

317 The draft in-service training strategy<sup>24</sup> uses  
 318 a standard learning resource package<sup>25</sup> as the  
 319 foundation for training curricula for different  
 320 health cadres. A team of trainers has been pre-  
 321 pared, three out of a planned 20 training sites  
 322 have been updated and the first batches have  
 323 received training. Concurrently work is ongoing  
 324 to incorporate training for skilled birth atten-  
 325 dants into pre-service courses for doctors and  
 326 certificate nurses. A multi-partner forum, jointly  
 327 chaired by the National Health Training Centre  
 328 and Family Health Division, provides technical  
 329 and strategic planning support for training,  
 330 acts as an advocacy body and will guide the  
 331 development of an integrated strategy cover-  
 332 ing deployment and support of trained skilled  
 333 birth attendants and information dissemina-  
 334 tion to promote utilisation of their services. A  
 335 holistic approach is essential for rational man-  
 336 agement of this critical resource and must be  
 337 linked to sector wide reform to address human  
 338 resource shortfalls.

339 In the Nepalese context of remote areas with  
 340 poor communications, skilled attendance for  
 341 home deliveries<sup>26</sup> or in local birthing centres  
 342 staffed by nurse-midwives<sup>27</sup> is recognised as a  
 343 realistic approach to preventing and managing  
 344 complications. SSMP is supporting a govern-  
 345 ment programme to design and build commu-  
 346 nity birthing centres attached to health posts.  
 347 The first of these are under construction and  
 348 should be staffed by at least two trained nurses  
 349 to provide 24-hour services. To address human  
 350 resource shortages, facility management com-  
 351 mittees are encouraged to use their own funds

**Table 1. Service utilisation at Lahan Hospital, July 2004–2007**

Fiscal year	Total deliveries	Major complications managed	Caesarean sections
July 2004–2005 (baseline)	933	Not recorded <sup>a</sup>	7
July 2005–2006	1,114	50	32
July 2006–2007	1,738	100	73

<sup>a</sup> The national system for recording major complications was only developed until the following year.

352 to hire additional nursing staff, and some have  
 353 already done so. In SSMP supported districts,  
 354 communities are involved in the management  
 355 and improvement of local facilities, to encour-  
 356 age them to trust these to meet their needs,  
 357 both for normal births and as a first step in seek-  
 358 ing emergency care. This is intended to over-  
 359 come the tendency observed during the Nepal  
 360 Safer Motherhood Project of families delaying  
 361 the decision to seek emergency care and bypass-  
 362 ing lower level facilities when the situation  
 363 becomes urgent.

### 364 **Increasing access**

365 Evidence shows that service availability alone is  
 366 not sufficient to increase utilisation and reduce  
 367 maternal mortality.<sup>28</sup> The Equity and Access  
 368 Programme, based on a scoping study in 2005,<sup>29</sup>  
 369 has been implemented for a year in eight selected  
 370 districts, and is an essential component of SSMP.  
 371 The rights-based conceptual framework<sup>30</sup> aims to  
 372 increase knowledge, empower women and their  
 373 families to access and demand services, build the  
 374 capacity of community organisations and man-  
 375 agement committees to plan and implement local  
 376 activities, and support local stakeholders to insti-  
 377 gate service improvements and advocate for  
 378 broader reforms. Social inclusion is woven into  
 379 the programming at every step. For example,  
 380 affirmative action principles have ensured recruit-  
 381 ment of women and representatives of different  
 382 ethnic groups to staff the programme, increasing  
 383 its acceptability and credibility at community  
 384 level. Demand creation works in tandem with ser-  
 385 vice strengthening activities, to avoid problems  
 386 caused by creating demand for services that do  
 387 not exist and to empower communities to lobby  
 388 for the establishment of services as their right.

389 Since experience shows that development  
 390 interventions often benefit the already relatively  
 391 advantaged,<sup>31</sup> pro-poor targeting is an integral  
 392 part of activities. The target areas have been  
 393 selected on the basis of having a high popula-  
 394 tion of socially excluded castes and ethnic groups,  
 395 remoteness and poverty. Social mobilisation activ-  
 396 ities, such as community meetings, street dramas,  
 397 financing and transport schemes, thus directly  
 398 target the disadvantaged as the majority popula-  
 399 tion of the area. Emergency funds and transport  
 400 schemes use money from village development  
 401 committees and savings groups. Behaviour change  
 402 communication interventions are based on the

national standard content and messages, but 403  
 “localised” by the development of local versions 404  
 of materials and radio programmes, using local 405  
 languages and culturally appropriate illustra- 406  
 tions. Transport schemes are similarly localised, 407  
 e.g. bicycle ambulances in plains areas and 408  
*dokas* (large baskets carried on the back of a 409  
 porter) in the hills. The local NGO partners work 410  
 with health service providers and community 411  
 influentials to address social barriers and atti- 412  
 tudes that may discourage poor and socially 413  
 excluded women from accessing services. 414

415 Two local NGOs have been contracted to 415  
 undertake regular interviews by specially trained 416  
 local women with local women, using non- 417  
 personalised techniques to encourage honest 418  
 communication about local issues and percep- 419  
 tions,\* exit interviews with women who have 420  
 received health services, and interviews with 421  
 service providers. The findings are shared in 422  
 constructive ways, enabling stakeholders to develop 423  
 locally appropriate solutions. After only one 424  
 round of such activities, bringing together ser- 425  
 vice users and providers has resulted in, for 426  
 example, health staff working their full hours, 427  
 providing clear information about services and 428  
 being more polite and respectful to patients. In 429  
 the next round, this experience will be used to 430  
 influence central policy development. 431

### 432 **Demand-side financing**

433 SSMP is supporting a Maternity Incentives 433  
 Scheme<sup>32</sup> to address financial barriers to women 434  
 accessing maternity services, which was initi- 435  
 ated by the Nepal government in all 75 districts 436  
 of the country in August 2005. It creates an 437  
 incentive to deliver in a health facility by cover- 438  
 ing transport costs for all pregnant women and 439  
 providing free services for women in 25 low 440  
 Human Development Index districts. There are 441  
 also financial incentives for service providers 442  
 assisting deliveries, either at home or in a health 443  
 facility, to encourage them to provide services. 444  
 In the 25 most disadvantaged districts, a facility 445  
 subsidy for each birth helps fund improvements 446  
 in services. Figures returned from the districts 447  
 (90% returned data in 2007) show that 52.5% of 448  
 the funds were paid to women, 45.4% to service 449  
 providers and 2.1% to institutions. 450

\* This technique, known as Key Informant Monitoring, was successfully used by the Nepal Safer Motherhood Project.

451 This is an ambitious scheme, which poses  
 452 complex management and information dissemination  
 453 problems, especially as it was initiated  
 454 in all 75 districts of the country at the same time.  
 455 A major challenge is ensuring that the most  
 456 needy women know about the incentives, as  
 457 they are likely to live furthest from a health  
 458 facility and be the hardest to reach with information.  
 459 Another challenge is establishing watertight  
 460 systems for financial management, ensuring  
 461 women are paid at the time of discharge from  
 462 the facility, with proper recording. After the  
 463 first year of implementation, initial findings  
 464 from an independent evaluation through the  
 465 Institute of Child Health in London\* indicated  
 466 that district managers were confused about the  
 467 scheme and practices varied considerably. In  
 468 response, the Family Health Division devoted a  
 469 full day at each of the five regional reviews  
 470 (May 2007) to explaining the scheme and listening  
 471 to feedback from district representatives. This  
 472 resulted in changes to the policy, implementation  
 473 guidelines and reporting formats, simplifying  
 474 and clarifying the process.

475 Although it is still early days, the scheme  
 476 appears to be encouraging more women to use  
 477 a health worker to assist at delivery or to have  
 478 an institutional delivery. While changes cannot  
 479 be solely attributed to the incentives, there was  
 480 a noticeable increase in the overall trend of  
 481 more deliveries being attended by a health worker  
 482 in the year after the scheme began. Official  
 483 figures show an increase of 3.2% (from 20.2%  
 484 to 23.4%) nationally compared with 2.0% in  
 485 each of the previous two years.<sup>23†</sup>

486 Demand-side financing for essential obstetric  
 487 care is a new concept in Nepal and the availability  
 488 of national and international evidence is limited.<sup>33</sup>  
 489 Good hospital leadership and proper briefing  
 490 of district managers about safe motherhood  
 491 issues and the incentives are critical to ensure  
 492 the scheme is locally understood, effectively  
 493 managed and well publicised. Experiences to  
 494 date indicate that, properly implemented, the  
 495 scheme can increase service utilisation and  
 496 hopefully prevent maternal deaths. There is  
 497 also a case for considering free services, which have

498 been successfully implemented in Uganda.<sup>34</sup> This  
 499 could be of greater financial benefit to women  
 500 than service fees offset by incentives, and reduce  
 501 administrative costs and complexity. However,  
 502 it would markedly increase costs to the health  
 503 system and might cause such rapid increase in  
 504 demand for services that quality of care would  
 505 suffer.<sup>34</sup> It is internationally acknowledged that  
 506 further study is required to fully assess the comparative  
 507 advantages of the two approaches.<sup>35</sup>

### 508 Monitoring and data collection

509 In Nepal, four key process indicators have been  
 510 monitored since 1997 in 13 of the 75 districts that  
 511 have received project support, either through the  
 512 Nepal Safer Motherhood Project or UNICEF. The  
 513 indicators include three of the six WHO/UNICEF/  
 514 UNFPA process indicators<sup>36,37</sup> and met need for  
 515 caesarean section, as this is more effectively  
 516 demonstrated graphically than percentage of caesareans,  
 517 which will always be very low. The indicators are:  
 518 percentage of births at an essential obstetric  
 519 care facility (normal plus complicated), met need  
 520 for emergency obstetric care (complications managed,  
 521 against an expected 15% complication rate), met  
 522 need for caesarean section and case-fatality rate.  
 523 Table 2<sup>38</sup> shows a trend of gradual increase in  
 524 service utilisation in the 13 districts, as measured  
 525 with these process indicators, from July 1997  
 526 to June 2006, with the average case-fatality rate  
 527 remaining below the 10% level considered  
 528 acceptable for quality services.

529 These trends are consistent with a decrease in  
 530 maternal deaths. Some contributing factors lie  
 531 outside the health sector, such as improved  
 532 education levels,\*\* but coverage of maternal  
 533 health services, which has a direct effect, has  
 534 increased, even in the poorer Mid- and Far-  
 535 Western regions, as evidenced by three  
 536 Demographic and Health Surveys, shown in  
 537 Table 3.

538 These data demonstrate the value of monitoring  
 539 of service delivery indicators. SSMP is supporting  
 540 the institutionalisation of process indicators into  
 541 the national Health Management Information  
 542 System, including development of tools and  
 543 training to move responsibility for data collection  
 544 and analysis from projects to the government  
 545 system.

\* Full report not yet available.

† Without statistical testing, these figures can only be taken as a positive indicator and trend.

\*\* Literacy was 51.2% for women over the age of six in 2006, up from 39.5% in 2001, according to the 2001 and 2006 Nepal Demographic and Health Surveys.

**Table 2. Trends in utilisation of obstetric care services in 13 UNICEF/NSMP project districts, process indicators for fiscal years July 1997–June 2006**

	1997–98	1998–99	1999–2000	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06
Met need for emergency obstetric care (%)	7.3	8.5	8.9	9.8	10.2	14.8	14.4	15.4	18.5
Births attended in a comprehensive emergency obstetric care facility (%)	4.0	4.7	6.0	6.3	6.6	7.4	7.3	7.2	11.1
Met need for caesarean section (%)	3.6	6.1	18.9	17.1	17.2	16.9	12.8	18.2	28.7
Case-fatality rate	0.5	0.6	0.2	0.5	0.1	0.1	0.3	0.7	0.4

544 In fiscal year 2006–07, 11 additional districts  
 545 began sending in these data and more districts  
 546 will join the scheme in 2007–08. All health facil-  
 547 ities providing essential obstetric care through-  
 548 out the country will receive training to ensure  
 549 collection of complete data. Disaggregation of  
 550 data by caste and ethnicity will be an essential  
 551 feature, to ensure that programmes are imple-  
 552 menting socially inclusive policies.

### 553 Discussion

554 National government and civil society efforts  
 555 have brought about the changes in maternal  
 556 mortality and in health service delivery and  
 557 many external development partners have sup-  
 558 ported them. Until recently the assumption among  
 559 development aid actors was that the key to sus-  
 560 tainability lay in encouraging developing country  
 561 governments to earmark funding from national  
 562 sources to scale up successfully piloted project  
 563 interventions. However, it is now acknowledged  
 564 that fragile states such as Nepal require contin-  
 565 uing financial support to enable them to guaran-  
 566 tee the uninterrupted high quality health services  
 567 encompassed by the concept of a sustainable  
 568 health service. SSMP has begun to scale down  
 569 its technical assistance, but the flow of finan-  
 570 cial aid from DFID will continue. The 2006 DFID  
 571 White Paper on reducing maternal mortalities<sup>39</sup>  
 572 talks of aiming for at least half of all future UK  
 573 direct support for developing countries to target  
 574 public services, such as health, education, water  
 575 and social protection, encouraging other donors  
 576 to commit to similar long-term, predictable fund-

ing support. At country level, advocacy is needed  
 for increased spending on health and can achieve  
 results, especially when there is public support for  
 it.<sup>40</sup> For the year 2006–07 only 6.4% of Nepal's  
 total expenditure was allocated to health, which  
 is about half that spent on education. The cur-  
 rent Nepal Health Sector Plan aimed for 7% by  
 2009. Internal and external advocacy and lobby-  
 ing resulted in an increase to 7.2% for 2007–08  
 with a recommended goal of 10%.<sup>41</sup>

There has been encouraging progress, despite  
 the limitations of complex bureaucratic systems,  
 frequent transfers of key government staff and  
 political instability, the result of Nepal's current  
 state of emerging democracy after ten years of  
 violent conflict. Unpredictable and sometimes  
 violent protests from various sectors of society,  
 political uncertainty and caution among gov-  
 ernment decision-makers about upsetting inter-  
 est groups are a constant source of delay. For

**Table 3. Percentage of live births delivered in a government, NGO or private health facility, by region, Demographic and Health Survey data, 1996, 2001 and 2006**

	Regions of Nepal					
	All Nepal	Eastern	Central	Western	Mid-Western	Far-Western
1996	7.6	7.2	11.3	7.4	2.7	3.9
2001	9.1	9.7	11.4	9.4	3.8	6.2
2006	17.7	16.6	24.1	17.4	13.6	8.5

597 example, agreement on the skilled birth attend-  
 598 ance training strategy has been delayed by oppo-  
 599 sition from paramedical staff who are not eligible  
 600 to become skilled birth attendants, and who fear  
 601 the erosion of their role and status. Shortage of  
 602 skilled professionals in rural areas, especially  
 603 doctors with surgical skills and experienced staff  
 604 nurses, remains a major constraint, exacerbated by  
 605 lack of systematic planning for training, deploy-  
 606 ment and support of these key staff. Despite these  
 607 challenges, substantial achievements in policy  
 608 and planning provide a foundation on which the  
 609 government can build future work. The long-  
 610 term Safe Motherhood and Newborn Health Plan  
 611 will guide programming until 2017; joint plan-  
 612 ning between the government and major exter-  
 613 nal partners has been initiated and the skilled  
 614 birth attendant and blood policies represent sig-  
 615 nificant developments.

616 Wider health sector reforms are essential if  
 617 the gains made in safe motherhood are to be  
 618 maintained and built upon, as many of the chal-

619 lenges are rooted in the overall health sector.  
 620 For example, human resource limitations require  
 621 a holistic human resource management strat-  
 622 egy with career paths that will encourage skilled  
 623 staff to stay in government service. Long-term  
 624 success lies in enhanced ability of the Nepal gov-  
 625 ernment to use this money effectively to build  
 626 on achievements and work collaboratively with  
 627 its partners to continue to make motherhood  
 628 safer in Nepal.

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 633 *Programs, providing technical support for behav-*  
 634 *iour change communication interventions; the*  
 635 *Technical Committee for Implementation of Com-*  
 636 *prehensive Abortion Care, supported by Ipas;*  
 637 *United Mission to Nepal and UNICEF, strength-*  
 638 *ening services in selected districts.*  
 639

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640 **Résumé**

641 Les données recueillies de 1997 à 2006 indiquent  
 642 des progrès dans la réduction de la mortalité  
 643 maternelle au Népal, mais les services de santé  
 644 publique sont encore limités par les pénuries de

**Resumen**

La evidencia reunida desde 1997 hasta 2006 indica  
 avances en la disminución de la mortalidad  
 materna en Nepal, pero los servicios de salud  
 pública aún se ven limitados por la escasez de

676  
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645 ressources et de personnel, particulièrement dans  
646 les zones rurales. Le Programme quinquennal de  
647 soutien à une maternité sans risque est fondé sur  
648 l'expérience du Projet népalais de maternité à  
649 moindre risque (1997-2004). Il travaille avec le  
650 Gouvernement népalais pour créer un ensemble  
651 minimum de services essentiels de maternité, en  
652 liant la définition de politiques à base factuelle au  
653 renforcement des systèmes de santé. Il a soutenu  
654 la planification à long terme, les activités pour que  
655 tous les accouchements bénéficient d'une assistance  
656 qualifiée, un approvisionnement sanguin sûr, la  
657 formation du personnel, la consolidation des  
658 capacités de gestion, l'amélioration des systèmes de  
659 suivi et l'utilisation d'indicateurs de processus, la  
660 promotion du dialogue entre les femmes et les  
661 prestataires sur la qualité des soins, et l'accroissement  
662 de l'équité et de l'accès au niveau des districts. Un  
663 plan finance les frais de transport de toutes les  
664 femmes enceintes jusqu'à un centre de santé et des  
665 primes d'encouragement pour les agents de santé qui  
666 supervisent les accouchements, avec des services  
667 gratuits et des subventions pour les équipements des  
668 25 districts les plus pauvres. Malgré la lourdeur  
669 de la bureaucratie, les transferts fréquents de  
670 fonctionnaires clés et l'instabilité politique, la  
671 définition des politiques a progressé et les dépenses  
672 de santé publique ont augmenté. Pour l'avenir, une  
673 stratégie de ressources humaines avec des plans de  
674 carrière qui encouragent le personnel qualifié à  
675 demeurer dans le secteur public est capitale.

recursos y personal, especialmente en las zonas 681  
rurales. El programa de Apoyo a la Maternidad Sin 682  
Riesgos, de cinco años de duración, se basa en la 683  
experiencia del Proyecto de Maternidad sin 684  
Riesgos (1997-2004), en Nepal. Está trabajando 685  
con el Gobierno nepalés a fin de desarrollar la 686  
capacidad para instituir un paquete mínimo de 687  
servicios esenciales de maternidad, vinculando la 688  
formulación de políticas basada en evidencia con el 689  
fortalecimiento del sistema de salud. Ha apoyado la 690  
planificación de largo plazo, procurando tener 691  
asistencia calificada en cada parto y suministros 692  
seguros de sangre, capacitando al personal, 693  
desarrollando la capacidad de administración, 694  
mejorando los sistemas de monitoreo y el uso de 695  
indicadores del proceso, fomentando diálogo 696  
entre las mujeres y los prestadores de servicios 697  
sobre la calidad de la atención, y aumentando la 698  
equidad y el acceso a nivel distrital. Una estrategia 699  
de incentivos financia los costos de transporte al 700  
establecimiento de salud para todas las mujeres 701  
embarazadas y los incentivos para que los 702  
trabajadores de la salud asistan en los partos, 703  
con servicios gratuitos y subsidios para los 704  
establecimientos en los 25 distritos más pobres. 705  
Pese a la burocracia, al traslado frecuente de 706  
personal gubernamental clave y a la inestabilidad 707  
política, ha habido avances en la formulación 708  
de políticas, y los gastos del sector salud pública 709  
han aumentado. En el futuro, es indispensable una 710  
estrategia de recursos humanos con trayectorias 711  
profesionales que motiven al personal calificado a 712  
continuar trabajando para el gobierno. 713