

Remote Area Focus

Given the special challenges faced by women living in remote areas, support will be needed to ensure implementation of the Remote Area Guidelines, based on local plans for improving access and services and the use of practical home and community based preventative measures.

Equity and Access

The success of the targeted equity and access interventions indicates the importance of scaling up this approach through direct district health office contracting of local NGOs, but the contracting process needs to be simplified and provision made for multi-year contracts, to ensure NGOs have sufficient implementation time. As a proven powerful tool, voice capture should be an integral part of equity and access work. At central level, the recently established Gender Equality and Social Inclusion unit will require continuing support to ensure the concepts are mainstreamed into all health interventions.

Aama Programme

As a successful equity and access measure, the Aama programme represents a key development in health financing, with a demonstrated potential to substantially increase facility deliveries and support poverty reduction efforts. However, this ambitious programme will require continuing support for implementing mechanisms that promote transparency and efficient cash flow, to ensure women benefit as intended and the system enables health facilities to receive and use the resources they need to fund essential services adequately.

Monitoring and Research

The new HSIS is still at pilot stage and will require a considerable amount of further support to ensure the whole system is functional and properly integrated, including all components and establishment of the National Health Information Centre and district information banks. This has the potential to significantly improve health planning through the easy availability of comprehensive data on all aspects of health. Preparations are already underway for the 2011 NDHS, and it will be important to ensure this provides the fullest possible information about

factors influencing the MMR, although it will not provide an estimate of the figure. The findings from the 2008/09 MMM Study have generated considerable interest among SMNH partners, and further research will be needed to determine how to best act on findings related to emerging new needs (such as the high rates of suicide) or existing needs that have not been fully addressed (such as eclampsia).

Final Words

On behalf of Options I would like to extend my sincere thanks to all our government colleagues, external development partners, implementing agencies, technical advisers, staff and consultants who have contributed with such passion to making SSMP so effective and professionally rewarding.

Many complex challenges remain, particularly related to improving the quality of services in remote rural areas, but MoHP's commitment to innovation and bold programming bodes especially well for the future. Nepal is also blessed with a large pool of highly talented sector professionals and it has been an enormous privilege to have worked with so many of them in the past five years. I am in no doubt that these dedicated individuals will be the principal cause of Nepal achieving MDG 5 and serve as an inspiration to all development actors in Nepal.

Greg Whiteside, Team Leader

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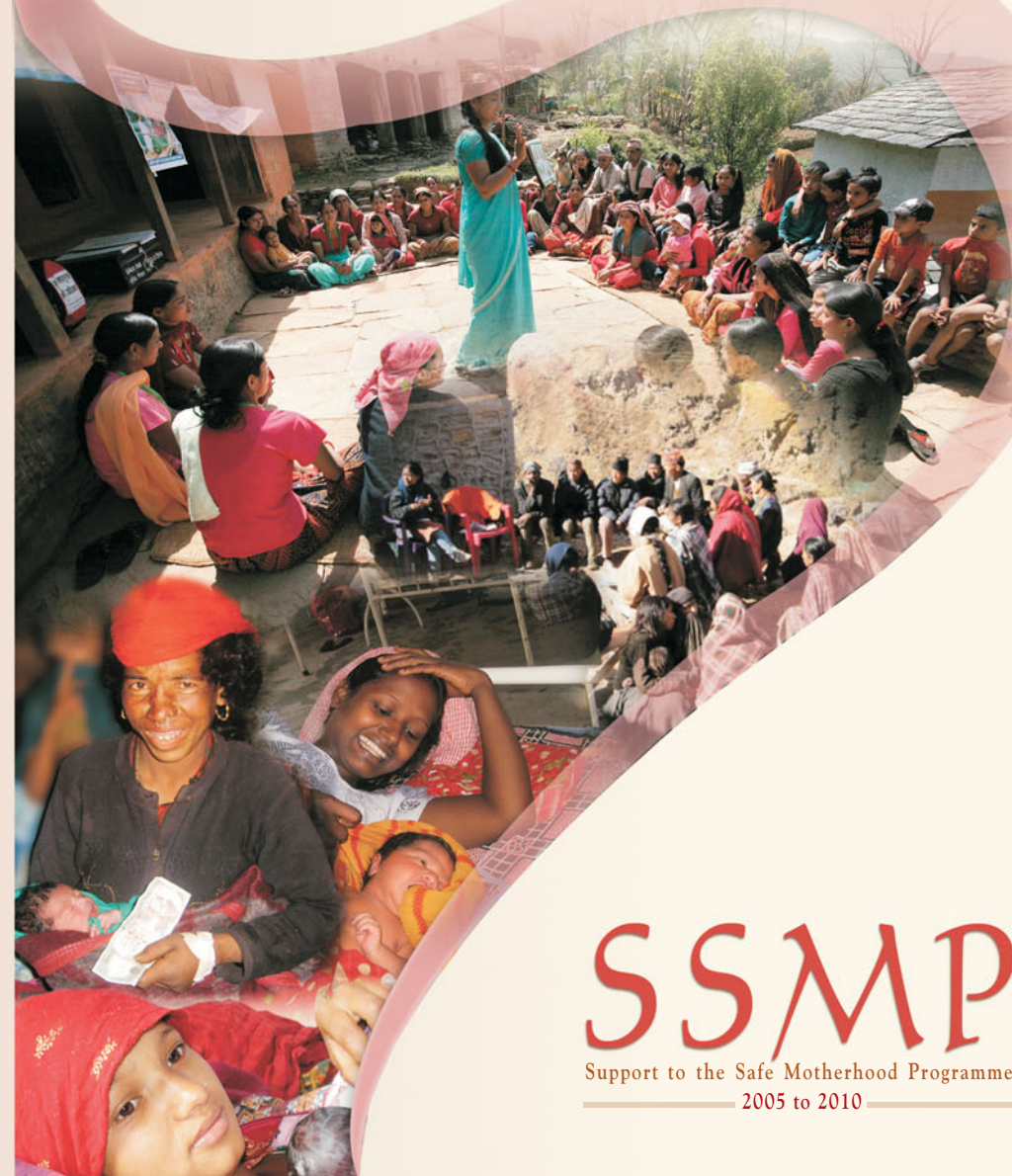
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Policy — Services — Access —



SSMP

Support to the Safe Motherhood Programme
2005 to 2010

Introduction

Support to the Safe Motherhood Programme (SSMP) was designed as a sub-sector programme, based on a set of complementary components to support the Ministry of Health and Population (MoHP) in implementing the National Safe Motherhood and Newborn Health (SMNH) Long Term Plan, 2002-17. Following the signing of an agreement between the Department for International Development (DFID) and the Government of Nepal, SSMP activities were initiated in early 2005, with technical assistance managed by Options Consultancy Services (UK) and financial aid paid directly to the Nepal Government. SSMP is closing in June 2010, and this leaflet provides a brief review of the key achievements and learning during the programme period, with recommendations for further development and scaling up. SSMP experience has contributed to the design of the next Nepal Health Sector Programme, 2010-15.



Programme Focus and Structure

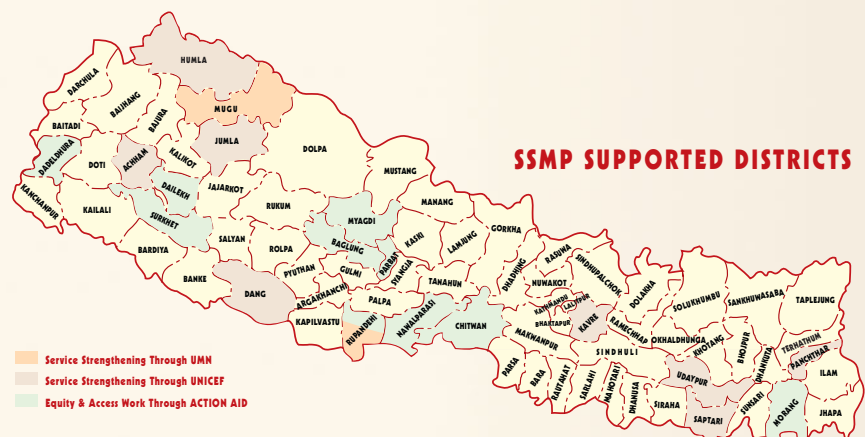
SSMP has specifically focused on:

- (1) Improving the **policy environment** and **systems** for delivering and improving access to maternal health care services
- (2) Increasing the availability and quality of maternal health care **services** for skilled delivery care, emergency obstetric care and safe abortion
- (3) Enhancing **access** to maternal health care services, especially for **poor and socially excluded** women.

The SSMP/Options core team of advisers, based in the Department of Health Services (DoHS), has worked on policy and planning issues with government colleagues in various divisions and centres and the (MoHP) itself. Although the main focus has been on maternal health, many of the inputs have sector wide significance.

SSMP/Options has also supported implementation of interventions in 19 districts through five contracted partners, feeding their experiences into advocacy and policy development:

- **ActionAid Nepal (AAN):** Equity and access in eight districts; mass media in two
- **Johns Hopkins Bloomberg School of Public Health /Centre for Communication Programmes (JHU/CCP):** Behaviour change communication at national level
- **Ipas Nepal:** Safe abortion at national level
- **United Mission to Nepal (UMN):** Services in two districts
- **UNICEF:** Services in eight districts



Future Directions

Continue strong support for maternal and newborn health in Nepal is expected under a new sector wide programme due to start in 2010. For this and other related programmes, some of the critical areas that the SSMP/Options team recommends for further support are:

Local delivery services

The momentum of increased availability and quality of 24-hour safe delivery services in peripheral health facilities, near to women's homes, needs to be maintained, as an important mechanism for encouraging facility delivery. This is especially important in the light of the expected increased demand resulting from the Aama Programme, to avoid overcrowding hospitals. Key approaches to developing these services are use of the appreciative inquiry review and planning process, local recruitment of ANMs (preferably on multi-year contracts, for continuity of service), development of speedy referral systems, upgrading of buildings and ensuring reliable medical supplies.



Emergency obstetric care

Ultimately all district hospitals should provide rapid response, high quality CEOC services. Continuing support will be required to establish and maintain this level of care, including infrastructure development; provision of the required human resources, especially surgically skilled doctors; and medical supplies. Expansion of safe blood transfusion services, with training, technical support and resources, will also be important.

Human resource development and management

Lack of appropriately placed skilled human resources remains the single biggest constraint to services, despite encouraging progress in SBA training and local contracting. Substantial inputs will be required to fully implement the 2009 Human Resource Strategy. This will entail improving personnel management (deployment, retention and working conditions), central information management (HuRIS), and training, especially for SBAs, anaesthetics assistants and operation theatre managers. In order to meet the Millennium Development Goals, 5,000 SBAs need to be trained by 2012 and a further 2,000 by 2015, which will require the development of more SBA training sites and capacity building for the National Health Training Centre to manage this.

Post-training follow up is an essential component of training, but has traditionally been neglected. This needs to be addressed to ensure all SBAs receive follow up support to maximise the benefits of the training. A pilot study supported by SSMP/Options demonstrated how SBA post-training follow up can be successfully carried out using the government system.



There is still a need to ensure pre-service training institutions adequately cover SBA skills, especially those affiliated to the Council for Technical Education and Vocational Training, which often provide insufficient clinical practice. Pre-service SBA education for ANMs is not yet covered, and needs to be addressed, possibly through a radical review of the whole course

Local recruitment, through central budgets and local resources, has successfully expanded the availability of ANMs and nurses at health facilities and should be continued. However, this has not helped address the critical shortage of doctors, especially in rural areas, and other approaches need to be developed and scaled up, such as bonded scholarships.

Infrastructure and procurement

There has been good progress in infrastructure development, based on the design of standard prototypes, the maintenance strategy and capacity building of engineers and technical monitoring staff, but ongoing monitoring support will be required to ensure completed buildings are properly utilised and adequately maintained.

Despite substantial efforts on the part of SSMP/Options and other partners, which has resulted in some progress, a number of governance related challenges remain. Continuing efforts will be required to support improved transparency of decision making and to introduce methods such as e-bidding to improve procurement processes.

✎ **Gender Equality And Social Inclusion:** Developed in 2009 and drawing strongly on the ActionAid Equity and Access Programme, SSMP supported the Health Sector Reform Support Programme in formulating this strategy, which includes the establishment of a specialised GESI unit in the MoHP to support mainstreaming of equity and inclusion in health programming.

✎ **Safe Delivery Incentives:** Initiated in 2005 across the whole country to address cost barriers to facility care, these incentives were shown by an evaluation in 2008⁵ to have increased the likelihood (by 24%) of women delivering in a government health facility.

✎ **Free Delivery Care:** Launched in January 2009, the Aama Programme combines incentives for mothers with free care at government and selected non-government health facilities, to further encourage poor women to access safe delivery care. Already there are indications of positive impact on increasing the number of facility deliveries.

✎ **Remote Area Guidelines:** Recognising the particular difficulties of under-served women in remote areas, these practical guidelines, approved in 2009, aim to address local needs through local planning, use of available transport options and appropriate, realistic, tried and tested community and home based interventions.



SSMP/Options has provided technical support for a range of national monitoring and independently commissioned research activities, to ensure the availability of a reliable evidence base for policy and planning and build the capacity of the government to commission and manage quality research. This included contributing to the design of the 2006 Nepal Demographic and Health Survey (NDHS), and carrying out a further analysis of the MMR data⁶ which provided greater insight into the factors influencing the reduction of the MMR. Major areas of achievement are:

✎ **Health Management Information System (HMIS):** Revised to be more comprehensive and accurate, with data on SBA deliveries, EOC services, safe abortion and private sector services, disaggregation by caste and ethnicity and using new denominators based on the 2006 NDHS.

✎ **Health Sector Information System (HSIS):** A huge undertaking to bring all national health information management under one integrated system, which has sector wide implications. It is currently being piloted in three districts

✎ **Health Infrastructure Information System (HIIS):** A newly established comprehensive electronic database containing details of all health buildings in the country, again with sector wide benefits.



✎ **Logistics Management Information System (LMIS):** A new electronic system, detailing all information about supplies and equipment for all health facilities, to improve planning.

✎ **Maternal Mortality and Morbidity (MMM) Study, 2008/09:** A landmark follow-on to the 1998 study, providing new insights into achievements and emerging needs in SMNH programming

✎ **Facility death auditing:** Evaluation and expansion of a national process for recording the circumstances of hospital maternal deaths, in order to improve quality of care and emergency response.

✎ **Rapid assessment:** Used chiefly for monitoring safe delivery incentives, this is now becoming more widely accepted as a cost effective tool for programme planning.

2. Service Strengthening

Although these cannot be solely attributed to SSMP, key improvements seen during the programme period include:

✎ **Increased service utilisation:** The percentage of pregnant women receiving four antenatal check-ups has increased from 39% in 2004/05 to 55% in 2008/09, and the percentage delivering in a health facility has risen from 11% in 2004/05 to 23% in 2008/09⁷.

✎ **Increased availability of EOC:** Expansion of CEOC services, from 34 facilities in 26 districts in 2004/05 to 76 facilities in 35 districts in 2009 (including private sector) and BEOC from only 18 facilities in 2004/05 to 90 in 2009, almost all government.

✎ **Increased met need for EOC:** This grew by an average of 2-3% per year for EOC and by 2-9% for caesarean section over the programme period.

✎ **Growth in local services:** The number of health posts offering 24-hour delivery services has substantially increased from a starting position of almost zero, to over 300 health posts and even some sub-health posts; greatly improving the access of poor rural women to facility care

Specific SSMP/Options areas of support contributing to these improvements include:

✎ **Appreciative Inquiry:** Forms the basis of a successful participatory review and planning process that builds the management capacity of health facilities and promotes good relationships between facilities and communities, resulting in improved services and increased utilisation⁸. The process was implemented in all partner districts and, with consultant support, the Government has scaled it up in a further 50 facilities in 28 districts, though trained government facilitators.

✎ **Local contracting of health workers:** Has helped address the acute shortages of staff at peripheral health facilities, especially for provision of 24-hour delivery care. It has proved particularly successful for Auxiliary Nurse Midwives (ANM), who are available in sufficient numbers locally and are the main maternal health care providers in peripheral areas. In the two years since the scheme was initiated, over 300 ANMs have been recruited on local contracts.



✎ **Human resource development:** SSMP/Options worked with partners to support the development of curricula, training materials and a five-year operational plan, including strengthening of 15 national training sites. Since January 2007, around 1,300 doctors, nurses and ANMs have received SBA training, 95 nurses have been trained as anaesthetics assistants and 74 have received operation theatre techniques and management training.

✎ **New health facility buildings:** A total of 21 new CEOC sites, 26 BEOC sites and 139 birthing centres have been built since the beginning of SSMP.

✎ **Better designed buildings:** Prototype designs have been developed for all levels of health facility, with flexible options to accommodate local conditions and needs, while maintaining the required standards. Birthing centres are now integrated in all new health posts and BEOC facilities in new primary health care centres.



✎ **Improved procurement procedures:** Introduction of e-bidding aims to ensure a more transparent environment for procurement and contracting, giving all potential suppliers a fair chance. This has been combined with more effective quality control mechanisms, using an external agency.

5. T. Powell Jackson et al, Evaluation of the Safe Delivery Incentive Programme, 2008

6. Options Further Analysis of NDHS data, 2008

7. It should be noted that the 2008/09 figure is based on a revised lower denominator, in line with reduced fertility rates found in the 2006 NDHS. If this denominator is used for 2004/05, it gives a figure of 14% instead of 11%.

8. M. Subedi, A.K. Paudel, Evaluation of Appreciative Inquiry Process for Health Facility Management Committees, 2009

3. Equity and Access

The SSMP Equity and Access Programme was designed to address barriers, including cost and social attitudes and practices, that prevent women accessing the care they need, especially those who are poor and excluded. Successful components of the programme are:



- ▶ **Targeted approach:** Rights based social mobilisation activities at district and community level, including establishment of emergency funds and transport schemes, have significantly improved safe motherhood knowledge, attitudes and practices among poor and excluded groups in the targeted areas.¹ Delivery service utilisation almost doubled in the three-year implementation period, with a greater increase among Dalit groups. As a result, Government has begun scaling up these activities in three new districts and new areas in seven districts, though direct NGO contracting by district health offices.
- ▶ **Voice capture:** This technique has enabled marginalised people to express their opinions and needs. Findings have informed national level advocacy and promoted local development, enabling stakeholders to better understand each other's perspectives. As a result, health facilities have improved their services and communities have helped address some of the constraints faced by health facilities



- ▶ **Communication materials:** Technical support has aided the development of standard messages and production of locally appropriate print materials and radio, including local radio programming based on a radio magazine format, which is now broadcasting from national Radio Nepal and six FM stations, reaching 35 districts.

The SSMP logical framework mirrors that of the National Long Term SMNH Plan, with the same goal and purpose and the same eight outputs.

The SSMP logical framework mirrors that of the National Long Term SMNH Plan, with the same goal and purpose:

Goal: Improved maternal and newborn health and survival, especially of the poor and excluded.

Purpose: Increased healthy practices and utilisation of quality SMNH services, especially by the poor and excluded, delivered by a well managed health sector.

Indicators

1. Increase in skilled attendance at birth by at least 4% per year, particularly for poor and excluded groups
2. Increase in deliveries conducted in health facilities by at least 2% per year particularly for poor and excluded.
3. Increased met need for EOC by at least 3% per year particularly for poor and excluded groups
4. Increased met need for caesarean section by at least 4% per year particularly for poor and excluded groups.

Key Achievements

There have been encouraging achievements in safe motherhood during the period of SSMP, the result of multiple Government and partner efforts and the influences of broader social, economic and political changes taking place. The most notable milestone is a reduction in the national Maternal Mortality Ratio (MMR), which has almost halved in ten years, to 281 maternal deaths per 100,000 live births.² Areas in which SSMP has significantly contributed are summarised below.



1. Policy and Information

SSMP/Options has worked with the Government and other partners to develop key policies and strategies, as a sound foundation for safe motherhood programming:

- ▶ **Safe blood:** An early achievement was the 2006 revised Safe Blood Policy and Guidelines, developed in collaboration with the Nepal Red Cross Society and National Public Health Laboratory. This increases the availability of safe blood services across the country, to support Emergency Obstetric Care (EOC) services.
- ▶ **Skilled Birth Attendance (SBA):** The 2006 national SBA Policy and 2007 In-Service SBA Training Strategy were the starting point for a major focus on production of SBAs,³ globally recognised as a key strategy for reducing maternal deaths.
- ▶ **Pre-service education strategy:** Curricula have been revised to incorporate SBA skills in pre-service education courses, and a strategy was developed in 2009 in collaboration with the Institute of Medicine. All medical and nursing schools affiliated to the IoM have adopted this, ensuring that, from 2011, graduates will qualify as SBAs without the need for further training.
- ▶ **Human resources for safe delivery:** Based on evidence from a study carried out in 2009 in 15 districts by the DFID supported Health Sector Reform Support Programme,⁴ this strategy aims to ensure the requisite teams of staff are in place for provision of safe delivery services at different levels of facility. This will also benefit other services.
- ▶ **Planned maintenance:** Using a new electronic health infrastructure database, this strategy, developed in 2007, outlines a system for planned and preventative maintenance of health buildings, a significant and cost effective step towards ensuring buildings remain fit for their purpose of providing quality services, which will also have sector wide benefits.



¹ Valley Research Group, End-line Survey on Knowledge Attitudes and Practices in Safe Motherhood, 2010

² 2006 Nepal Demographic and Health Survey.

³ Doctors, nurses and ANMs trained in the internationally defined SBA skills

⁴ The HSR-SP study: RTI, 2009, Human Resource Strategy Options for Safe Motherhood, Research Triangle Park, NC, USA