

National Safe Motherhood and Newborn Health - Long Term Plan

(2006-2017)



Government of Nepal
Ministry of Health and population
Department of Health Services
Family Health Division
2006



Government of Nepal

Ministry of Health & Population



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Ramshahpath, Kathmandu
Nepal

Date: 12th December 2006
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Few Words

The Government of Nepal is committed to provide 'essential health care services' to all particularly the poor and socially excluded people of Nepal. Safe motherhood is a key component of the essential health care services having direct relation with women.

In the light of changing social, political and demographic dynamics, it had become necessary to revise the existing plan related to the Safe Motherhood and Newborn Health. This plan follows the millennium development goals in achieving the three fourth reductions in maternal mortality ratio and two third reductions in the under-five mortality rate by the year 2015. It is in this context, I am pleased to endorse the *National Safe Motherhood and Newborn Health Long Term Plan, 2006-2017*.

I would like to reiterate that the government is fully committed to meet the goals set out in this plan. I call upon the health workers from public, private and non-government sector to reinvigorate in achieving these challenging goals. The support of external donor partners has been very crucial in the achievements in health sector so far. I strongly believe that Nepal will receive increased support from the external donor partners in the areas of safe motherhood and newborn health in order to achieve overall health outcomes.

Amik Serchan
Deputy Prime Minister
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Date: December 19, 2006

Foreword

National Safe Motherhood and Newborn Health Long Term Plan 2006-2017 is the second version of the National Safe Motherhood Long Term Plan 2002-2017. The revision was necessary to ensure compliance with the Millennium Development Goals and the Nepal Health Sector Programme - Implementation Plan 2004-2009. This document provides guidelines for policy makers, line ministries, external development partners, local NGOs and private health sector organisations to identify their roles and responsibilities and enable them to develop and implement activities within the framework of the plan.

The national safe motherhood programme has grown significantly since its initiation in 1993, and now specifically includes newborn health. Within the health sector, safe motherhood and newborn health are top priorities of Government of Nepal, as well as External Development Partners. This plan documents the long-term vision of the safe motherhood and new born health of Nepal, and will help to identify key output areas and implement activities to achieve the purpose and goal set out to all working in this sector. The goal of three quarters reduction in maternal mortality as a millennium development goal is a challenge, and we need to put serious effort at all levels.

This plan was prepared using a participatory approach and following rigorous processes that included collection of information, a desk review of various documents and a series of workshops. The participants in the workshops included representatives from government, external development partners and the non-government sector. I like to thank all the individuals and organisations who contributed in preparing this document.

Ramchandra Man Singh
Secretary



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Preface

Nepal is committed to achieve the Millennium Development Goal. It is a challenge to the health system of Nepal to reduce maternal deaths by three-quarters by the year 2015. The revised safe motherhood long term plan takes into account recent developments such as the growing realisation for specific emphasis on neonatal health, recognition of the critical role of skilled birth attendance in reducing maternal and neonatal mortality, health sector reform initiatives, legalisation of abortion, recognition of the significant levels of mother to child transmission of HIV/AIDS and increased emphasis on equity issues in safe motherhood services.

The previously developed safe motherhood plan had several limitations to move towards the millennium development goal. The plan has been revised in line with MDG and draws from Nepal Health Sector Programme Implementation Plan's (NHSP-IP) eight outputs including the public private partnership and decentralisation. It is very satisfying to note that this plan is revised through the intensive participation of government, non-government, external development partners, professional organisations and other stakeholders. I highly appreciate sincere hard work of the Family Health Division staff and Support to the Safe Motherhood Programme team in development of the plan in present form. I commend the wise and intellectual inputs of all participants in the development of this plan. I am confident that this plan will help in developing periodic as well as annual plans and their effective implementation.

Dr. Mahendra Bahadur Bista
Director General

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Acknowledgements

This document is the outcome of long discussion and engagement among a group of experts and professionals, and I sincerely thank all of them for their invaluable contribution. I would like to express my gratitude to directors of various divisions and centers in the Ministry of Health and Population and the Department of Health Services.

I would like to specially thank the Nepal Society of Obstetricians and Gynecologists (NESOG) for undertaking the desk review of existing plan documents related to safe motherhood and newborn health. I would like to thank the HURDEC for successful facilitation of three workshops through which the logframe was developed. I very much appreciate and thank the *Support to the Safe Motherhood Programme* (SSMP) team for their valuable inputs in bringing this document to its final shape.

Dr. B. K. Suvedi
Director

List of Acronyms

ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
BCC	Behaviour Change Communication
BEOC	Basic Emergency Obstetric Care
CAC	Comprehensive Abortion Care
CBO	Community Based Organisation
CBS	Centre Bureau of Statistics
CDP	Community Drug Programme
CEDAW	Convention for the Elimination of Discrimination Against Women
CEOC	Comprehensive Emergency Obstetric Care
CHD	Child Health Division
CTEVT	Council for Technical Education and Vocational Training
DACC	District AIDS Coordination Committee
DDA	Department of Drug Administration
DDC	District Development Committee
DHMC	District Health Management Committee
DHS	Demographic and Health Survey
DoHS	Department of Health Services
DUDBC	Department of Urban Development and Building Construction
EDP	External Development Partner
EHCS	Essential Health Care Services
ENC	Essential Newborn Care
EOC	Emergency Obstetric Care
FCHV	Female Community Health Volunteer
FHD	Family Health Division
FMIS	Financial Management Information System
HEFU	Health Economics and Financing Unit
HMIS	Health Management Information System
HP	Health Post
HURDEC	Human Resource Development Centre
HURIC	Human Resource Information Centre
IEC	Information Education Communication
IMCI	Integrated Management of Childhood Illness
IOM	Institute of Medicine
KAP	Knowledge Attitudes and Practice
LMD	Logistics Management Division
LMIS	Logistics Management Information System
LSGA	Local Self Governance Act

LSI	Livelihood and Social Inclusion
MBBS	Bachelor of Medicine Bachelor of Surgery
MDG	Millennium Development Goal
MOF	Ministry of Finance
MOGA	Ministry of General Administration
MoHP	Ministry of Health and Population
MOLD	Ministry of Local Development
MPPW	Ministry of Planning and Physical Works
MRT	Midwifery Refresher Training
NAN	Nursing Association of Nepal
NNC	Nepal Nursing Council
NEPAS	Nepal Paediatric Society
NESOG	Nepal Society of Obstetricians and Gynaecologists
NGO	Non Government Organisation
NHEICC	National Health Education Information Communication Centre
NHTC	National Health Training Centre
NHSP-IP	Nepal Health Sector Programme-Implementation Plan
NLSS	National Living Standard Survey
NMC	Nepal Medical Council
NSMNH-LTP	National Safe Motherhood Newborn Health -Long Term Plan
PAC	Post Abortion Care
PCL	Proficiency Certificate Level
PESON	Perinatal Society of Nepal
PHCC	Primary Health Care Centre
PMTCT	Prevention of Mother to Child Transmission
PNC	Post Natal Care
PPP	Public Private Partnership
RH	Reproductive Health
RHCC	Reproductive Health Coordination Committee
RHD	Regional Health Directorate
RHTC	Regional Health Training Centre
SBA	Skilled Birth Attendant
SHP	Sub Health Post
SMNF	Safe Motherhood Network Federation
SMNH	Safe Motherhood and Newborn Health
SMNSC	Safe Motherhood and Neonatal Sub Committee
SN	Staff Nurse
SSMP	Support to the Safe Motherhood Programme
TMIS	Training Management Information System
TT	Tetanus Toxoid
UNFPA	United National Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VDC	Village Development Committee
WHO	World Health Organisation

Executive Summary

This revised National Safe Motherhood and Newborn Health Long Term Plan (NSMNH-LTP) 2006-2017 has been developed to be in line with the Second Long Term Plan Health Plan (1997-2017), the Nepal Health Sector Programme Implementation Plan and Millennium Development Goals (MDG). The revision takes into account recent developments such as the increased specific emphasis on neonatal health, recognition of the importance of skilled birth attendance in reducing maternal and neonatal mortalities, health sector reform initiatives, legalisation of abortion, recognition of the significant levels of mother to child transmission of HIV/AIDS and increased emphasis on equity issues in safe motherhood services.

The overall goal of this plan is to improve maternal and neonatal health and survival especially among poor and socially excluded communities, with indicators drawn from the MDGs. These include a reduction in the maternal mortality ratio to 134 per 100,000 live births by 2017 and a reduction in the neonatal mortality ratio to 15 per 1,000 live births by 2017.

The purpose is increased healthy practices and utilisation of quality maternal and neonatal health services, especially by the poor and excluded, delivered by a well-managed health sector. The indicators are an increase in the number of deliveries assisted by Skilled Birth Attendants (SBA) to 60 percent by 2017 and increase in the number of deliveries in a health facility to 40 percent by 2017. Met need for Emergency Obstetric Complication will be increased by 3 percent each year and the met need for Caesarean Section by 4 percent each year.

Eight key outputs have been identified, with individual indicators and key activities:

1. Equity and Access

The purpose is to ensure that individuals, groups and networks are socially empowered to practise desired Safe Motherhood and neonatal Health (SMNH) behaviours, leading to increased equity of and access to health services. The key activity areas are in advocacy, social mobilisation and behaviour change communication.

2. Services

The purpose is to enhance equitable provision of quality SMNH services. These include: focused antenatal care, delivery and newborn care by skilled birth attendant, postnatal care, emergency obstetric care, comprehensive abortion care and referral services. Activity areas include strengthening and expansion of SMNH services, improvement in quality of services, reaching socially excluded groups, creating an enabling environment for services and developing appropriate linkages.

3. Public Private Partnership

The purpose is to increase participation of the private sector, NGOs, community based organisations and professional/academic institutions in SMNH related public services to ensure consumers have equitable access to affordable services.

4. Decentralisation

The purpose is to enhance local government and partner capacity to plan and oversee SMNH services in line with the Local Self Governance Act (LSGA).

5. Human Resource Development: Skilled Birth Attendant Strategy

The purpose is to develop and implement a strategy and plan for human resource development in safe motherhood and neonatal health, particularly skilled birth attendant training.

6. Information Management

The purpose is to develop a comprehensive sector wide SMNH information base and to incorporate and utilise this within the Health Information System to support policy, planning, monitoring, evaluation and advocacy at national and local levels. Key activity areas include information management, data collection and quality, access to information and monitoring.

7. Physical Assets and Procurement

The purpose is to ensure adequate physical resources for SMNH services along with year round availability of SMNH related drugs and supplies. Key activity areas include construction and maintenance, planning and quality assurance and distribution of drugs and commodities.

8. Finance

The purpose is to ensure improved sustainable financing systems for SMNH services. Key activity areas include mobilisation of resources, alternative financing systems and formation of safety nets for the socially excluded.

Seven cross cutting issues and approaches were identified, which are common to all the outputs. These are: social inclusion, gender, rights based approach, research and advocacy, enabling environment, public private partnership and decentralisation.

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Chapter 1:

Introduction and Background

1.1 Introduction

The overarching goal of development efforts in Nepal is to reduce poverty, as highlighted in the Tenth Plan (Poverty Reduction Strategy Paper) 2002-2007, and health sector development efforts are treated as an integral part of this strategy. The Ministry of Health and Population (MoHP, formerly Ministry of Health) developed the Second Long Term Health Plan (1997-2017) as a sectoral perspective plan and the National Safe Motherhood Long Term Plan (NSMLTP) (2002-2017) was based on this document as a sub sector plan, in line with the Nepal Health Sector Programme Implementation Plan (NHSP-IP) 2004-2009.

Within the health sector, safe motherhood has been a national priority programme for the last decade, and is highlighted in all major health related policies and plans. The Tenth Plan, the Second Long Term Health Plan and the NSMLTP (2002-2017) all highlight the need to reduce the high levels of mortality among women, infants and children. The Millennium Development Goals (MDG) specify a two thirds reduction in the under-five mortality rate and 75 percent reduction in the maternal mortality ratio by the year 2015. The NHSP-IP draws on the Millennium Development Goals, with the stated purpose of improving the health status of the Nepalese population through utilisation of essential health care services (EHCS), specifying maternal mortality and infant and child mortality reduction among other essential health care indicators. Since safe motherhood and newborn health are not purely health issues, they warrant a multi-sectoral approach, and the role of other sectors is particularly important in enhancing access and promoting equity. This is acknowledged in the NSMLTP and outputs are related to programmes in education, information and communication, transport and local development, as appropriate.

The NSMLTP outlines strategic directions and defines the major outputs and general areas of activity, but without a more specific set of activities, detailed costing is beyond its scope. This will be included on a three-year rolling basis with implementation planning.

1.2 Rationale for Revision of the National Safe Motherhood Long Term Plan (NSMLTP 2002-2017)

In recent years many safe motherhood stakeholders, both government and non-government, at district, regional and national forums, have noted gaps in the original NSMLTP and advocated for its revision and updating. In order to retain its effectiveness as a guide to programming, the plan needs to be treated as a rolling document, and revised regularly, in line with the changing context of new developments. A number of specific issues have been identified that highlight the urgent need for revision as follows:

MDGs and Neonatal health: The NSMLTP (2002-2017) was developed before the Millennium Development Goal Country Report was prepared, and so was unable to fully take into account the recommendations it contained. For example, prior to this little attention had been paid to neonatal health in its own right, but the MDG report highlighted the growing recognition that safe motherhood should specifically incorporate newborn health. The infant mortality rate in Nepal is declining but only slowly - child mortality declined by 34 percent between 1996 and 2001, but during the same period infant mortality declined by only 18 percent. Since two thirds of infant deaths occur in the neonatal period, significant reduction of infant mortality rates depends on a decrease in the neonatal mortality rate. While it is understood that safe motherhood interventions do contribute to a reduction of perinatal and neonatal mortality, in order to achieve the substantial infant and child mortality reductions encompassed by the MDGs, additional specific newborn health interventions need to be integrated with safe motherhood programming. The National Neonatal Health Strategy and National Neonatal Health Long Term Plan formulated in 2004 and 2005 respectively to address neonatal health issues had also not been incorporated into the previous plan.

Skilled birth attendance: The original NSMLTP (2002-2017) placed little emphasis on the importance of skilled birth attendance in the drive to reduce maternal and neonatal mortalities. Global standards for what constitutes skilled birth attendance and how a skilled birth attendant (SBA) is defined have also changed significantly in the last few years. The National SBA Policy has been only recently formulated and endorsed, and key points from this need to be incorporated into the current plan.

Health sector reform: The NSMLTP (2002-2017) pre-dated the recent work on health sector reform and strategy development, and the outputs of Nepal Health Sector Strategy and Nepal Health Sector Programme Implementation Plan (2004-2009) need to be included.

Abortion: The legalisation of abortion under specified conditions in 2002 has resulted in an intensive programme to establish comprehensive abortion care (CAC) services in public hospitals from 2004 and a commitment to integrating CAC into safe motherhood programming. This important step acknowledges the significant effect of complications due to unsafe abortions on the high maternal mortality ratio in Nepal and was not included in the original NSMLTP (2002-2017).

Mother to child transmission of HIV is an increasing problem. As HIV infection rates grow, this is likely to become major issue in the near future for service provision. As it is a recently acknowledged phenomenon, prevention activities are not mentioned in the original NSMLTP. Prevention of mother to child transmission (PMTCT) needs to be incorporated in the current plan.

Equity issues in access and utilisation of safe motherhood and neonatal health (SMNH) services are not mentioned in the original NSMLTP and are of critical importance if the most needy members of society are to be targeted and the MDGs achieved.

1.3 The Revision Process

Revision of the plan was carried out in three stages, with the participation of multiple stakeholders, both government and external development partners (EDP). The list of participants is shown in the annex.

1. **A preparatory meeting** of potential participants was held in November 2005, to share the rationale for revision and the proposed methodology for the

process. The meeting determined the parameters, boundaries and broad outputs and assigned tasks. Working groups for different outputs were formed on the basis of professional expertise, and possible reviewers suggested.

2. In preparation for the **first workshop**, held in January 2006, consultants reviewed existing national policies, strategies and plans, to identify the gaps, deficiencies and discrepancies, and prepared a background paper for presentation at the workshop. Based on this review, an analysis of the strengths, weaknesses, opportunities and threats of the existing plan was carried out. The groups then worked to analyse and update the individual outputs and associated activities for the plan, and presented their ideas in a plenary session for further discussion and refining. By the end of the workshop a first draft revision of the plan had been prepared.
3. Each group met at least twice before the **second workshop**, which was held in March 2006. During this period they refined the output statements, developed a full set of activities under each output and agreed on indicators and their means of verification. Cross group sharing helped to avoid the duplication and ensure consistency in the plan, and groups consulted with other experts for technical inputs. At the second workshop groups presented their work for comments and suggestions, on the basis of which the draft plan was refined and finalised. Risks and assumptions were developed and groups drafted a brief narrative of their output.

1.4 Goal, Purpose and Outputs

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

The key indicators for this NSMNH-LTP goal are:

1. A reduction in the **maternal mortality ratio** from 539 per 100,000 live births¹ to 134 per 100,000 by 2017
2. A reduction in the **neonatal mortality ratio** from 39 per 1,000² to 15 per 1,000 by 2017.

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

Key indicators for this include:

1. Increase in the percentage of deliveries assisted by an SBA to 60% by 2017
2. The percentage of deliveries taking place in a health facility increased to 40% by 2017
3. Increase in met need for emergency obstetric care of 3% per year
4. Increase in met need for caesarean section of 4% per year.

Outputs: Eight outputs are specified in the plan, each with individual indicators.

1. Equity and access
2. Services
3. Public private partnership
4. Decentralisation
5. Human resource development: Skilled birth attendant strategy
6. Information management
7. Physical assets and procurement
8. Finance

¹ Nepal Family Health Survey 1996

² Demographic and Health Survey 2002

1.5 Definition of terms

In order to ensure consistency and clarity, technical terms used regularly among safe motherhood stakeholders are defined below, as used in this document.

Poor: Classification of poverty is based on the annual expenditure on food and non-food items. The official poverty line developed for the year 2003/4 by the Nepal Central Bureau of Statistics is a total real per capita consumption of NRs.7,696 (approximately US\$102) per year³. The food poverty line is based on an energy intake of 2,144 Kcal per person, per day.

Social exclusion; A process and state that prevents individuals or groups from full participation in social, economic and political life and from asserting their rights. It derives from exclusionary relationships based on power and may relate to caste, ethnicity, religion or gender status.

Social Inclusion: The removal of institutional barriers and enhancement of incentives to increase the access of diverse individuals and groups to development opportunities (World Bank).

Social empowerment: Improvements in knowledge, attitudes, behaviours, confidence, legal and social status and access to resources, including transport and finance schemes, among individuals, groups and networks. The World Bank defines empowerment as: The enhancement of assets and capabilities of diverse individuals and groups to function and to engage, influence and hold accountable the institutions that affect them.

Enabling environment: The existence of support (physical and social/attitudinal) that promotes and enables desired behaviours or service provision.

Comprehensive abortion care (CAC): Legally available elective induced abortion service that includes safe techniques (manual vacuum aspiration and effective pain management), counselling and post procedure contraception services.

1.6 Cross cutting issues and approaches

Social inclusion

Social exclusion, due to caste, ethnicity, age, religion or gender, is a major cause of poverty, affecting access to and utilisation of essential health care services (EHCS). A number of institutional barriers have been identified related to access and utilisation by these groups, and the Vulnerable Community Development Plan was developed as a part of the Nepal Health Sector Implementation Plan (2004-2009) to directly address these and ensure poor and excluded people have equitable access to EHCS. This includes increasing the coverage and raising the quality of EHCS, with special emphasis on improved access for poor and excluded groups. Thus social inclusion has emerged as a major social, economic and political policy issue, which is high on the agenda of policy makers and planners. Since SMNH services are a major component of EHCS, the NSMNH-LTP mainstreams social inclusion as a cross cutting issue in its goal, purpose and all outputs. Related annual plans will specifically address the needs of socially excluded groups, and progress in reaching them will be monitored by means of disaggregated indicators. Priority will be given to infrastructural and resource needs in areas serving socially excluded groups, and communities will be encouraged to identify and support the training of women from these groups as SBAs and create an enabling environment for them to serve their communities. Access activities will encourage self-confidence, voice and agency, especially among women and other socially excluded and vulnerable groups and will engage them in an inclusive and empowering way.

³ Adjusted to NRs.11,057 for Kathmandu, NRs.7,901 for other urban areas, NRs.8,902 for rural western hills, NRs.8,070 for rural eastern hills, NRs.7,418 for rural western terai, NRs.6,079 for rural eastern terai.

Gender

As an excluded group in themselves, and as the key beneficiary targeted by safe motherhood interventions, the needs of women are treated as paramount throughout the NSMNH-LTP, not simply as individuals, but as members of families and communities functioning within complex relationships and social expectations. Gender issues are included as a cross cutting issue and an important part of all the outputs, but particularly in human resource development and deployment, management approaches and access activities.

Rights based approach

Human rights standards relevant to maternal health include, but are not limited to:

- The right to life and survival
- The right to the highest attainable standard of health
- The right to decide freely the number and spacing of one's children
- The Convention for the Elimination of Discrimination Against Women (CEDAW).

The right to life and health through access to essential health care services, and specifically SMNH services, is thus a basic human right, and one that is denied to countless women in Nepal. Behind every preventable maternal death lies a failure to assure women's rights, linked to social issues such as the low status of women, their lack of decision-making power, poor access to information and care, restricted mobility, early age of marriage, and the low priority and resources given to their health. There are also marked disparities by social group in women's access to skilled birth attendance and to essential obstetric care. Achieving improved and more equitable maternal survival will thus require political, social, legal and economic actions as well as scaling up technical strategies. Traditional public health and health systems approaches must therefore be combined with a human rights-based approach.

Rights based approaches are therefore included as fundamental and cross-cutting to all outputs of the NSMNH-LTP, with the aim of increasing accountability for maternal and neonatal health, strengthening local capacity of duty-bearers to fulfil women's rights, strengthening women's voices and their ability to demand their rights to maternal health and transforming the distribution of power and resources that maintain inequalities across society, in families, communities and health systems.

Research and advocacy

Improving the quality and utilisation of evidence in policy and practice can help save the lives of mothers and their newborns. Research provides the scientific evidence needed to improve the quality and safety of SMNH services, reduce costs and broaden access. It also informs advocacy, which at central level plays vital role in developing favourable policies and plans and at community level is important in raising public awareness of key health and social issues and creating demand for services. Thus research and advocacy are incorporated as important cross cutting issues in all outputs of the NSMNH-LTP.

Enabling environment

Simply providing training and facilities or undertaking access activities, are not enough to ensure women receive high quality SMNH services. An enabling environment is important in supporting staff in facilities and motivating them to provide high quality services. This means that human resource development must go hand in hand with upgrading of infrastructure, provision of equipment and supplies. An enabling

environment is also important at community level to support women in making healthy reproductive health choices and carrying them through. It encourages people to utilise health services within any given social context, using local knowledge, perceptions and values, relevant traditional practices, preferences and beliefs to enhance knowledge and awareness. Sensitivity to the effects of the armed conflict, which has already been reported to negatively impact women's access to SMNH services will also be important.

1.7 Risks and assumptions

Key assumptions on which the NSMNH-LTP is based include:

1. Continuing political commitment to safe motherhood and neonatal care as a high priority in both policy and programming, including allocation of resources
2. Effective and timely execution of the Nepal Health Sector Programme Implementation Plan
3. Social, political and economic stability, enabling activities to be carried out as planned and resources accessed as needed
4. Resolution of the conflict and/or development of effective strategies for working safely and effectively in conflict affected areas, such as using locally acceptable community workers as bridging people and using rights based messages and approaches
5. Elected leaders in place in functional district and village development committees, able to facilitate devolved decision-making, local ownership and accountability
6. Commitment to local level capacity building and support, combined with decentralisation, to ensure quality services.

Chapter 2:

Description of the Outputs

The outputs are derived from NHSP-IP and so are closely linked with it. This plan however, elaborates the outputs with a focus on maternal and newborn health concerns.

Output 1:	Equity and Access
Purpose:	Individuals, groups and networks socially empowered to practise desired SMNH behaviours, leading to increased equity of and access to health services.
Lead Agency:	This output will be led by National Health Education, Information and Communication Centre (NHEICC) mainly in collaboration and coordination with the Family Health Division (FHD) and Child Health Division (CHD) and other relevant Divisions within the Department of Health Services, development partners, NGOs, civil society, networks, federations, groups and individuals.

Background

Increasing equity of and access to SMNH services requires changes in national, community and household level behaviours and expectations. This is not only true for preventative and promotive services, but also for timely treatment of complications in which dangerous delays are common. A combination of mutually reinforcing approaches - advocacy, social mobilisation and BCC - has proved successful in addressing barriers to services in Nepal. These three approaches, combined with the provision of quality services, will be critical to improving the health of mothers and newborns and reducing the three delays responsible for so many maternal and neonatal deaths.

This output will seek to promote gender and social inclusion as cross cutting issues, and to address equity issues in order to expand the reach of services to the poor and socially excluded. Specific localised advocacy, social mobilisation and BCC activities, linked to increased availability of services, will address barriers to health services among poor and socially excluded groups. Access activities will work to encourage self-confidence, voice and agency, especially among women and other disadvantaged groups and to engage poor and socially excluded communities in inclusive and empowering way.

Equity and access outputs will seek to create an enabling environment that encourages people to utilise health services within any given social context. Activities will advantageously use local knowledge, perceptions and values, relevant traditional practices, preferences and beliefs to enhance knowledge and awareness and will be sensitive to conflict issues. Access embraces financial, institutional and infra-structural factors including, but not limited to, funding, transportation

and education. It also relies upon positive and welcoming service provider attitudes, trust, honesty, responsiveness, accountability and quality service delivery both at established facilities and through outreach programmes.

Activity areas

A. Advocacy

Advocacy will be a key component for increasing equitable access to SMNH services. In order to ensure coordinated, supported and sustained advocacy activities, action forums (existing if possible) at national and district levels and comprising a wide range of government and NGO partners, journalists and the private sector will be mobilised to develop and implement specific action plans. Activities will include lobbying for the formation or updating of appropriate policies for social empowerment, increased resources for SMNH programmes and provision of at least one telephone in each health facility. The action forums will raise the profile of SMNH through a range of activities, such as publishing articles and organising public events. Advocacy will focus at different levels through partnerships and collaboration with relevant stakeholders to incorporate the voices of users and providers. This output will be closely linked with Output 8, Finance.

B. Social Mobilisation

Social mobilisation activities are important for ensuring the involvement of people at all levels and obtaining support for safe motherhood activities. Activities will be carried out at national, district and community levels, in collaboration with safe motherhood partners and stakeholders from other sectors (inter and intra ministerial, divisional, NGO) and line agencies. The programme will use participatory approaches to encourage communities to take ownership of the drive to improve the health of the mothers and newborns. Safe motherhood programme implementers will support the strengthening of existing committees. The capacity of community groups and networks will be enhanced to create and utilise sustainable emergency funds and transportation schemes. Referral systems will be supported at all levels (linking with Output 2, Services).

C. Behaviour Change Communication (BCC)

BCC informs people about safe motherhood and neonatal health issues and the services available and promotes positive behaviours. Mass media, local media and inter-personal communication will be used to disseminate and reinforce messages. BCC strategies will ensure that consistency of messages is retained through all channels used, so that people are able to understand messages within their own context and act on the information received. There will be a strong focus on using localised approaches to cater to the needs of different target audiences, particularly reaching out to poor and socially excluded communities. BCC interventions will need to go hand in hand with service availability, and will therefore be closely linked with Output 2, Services.

The Safe Motherhood Information Education Communication (IEC) strategy (2003-2008) will be updated to incorporate research-based and standardised messages. It will be implemented through focused communication interventions that reach out to poor and socially excluded groups. Rights-based approaches will be used to promote service utilisation, especially skilled attendance at childbirth, and reduce violence against women. There will be an increased emphasis on birth preparedness and complication readiness as well as renewed attention to enhancing positive non-discriminatory interpersonal communication between providers and clients. Cost sharing initiatives will be promoted as appropriate, linked with Output 8, Finance.

Output 2: Services

Purpose: Enhanced and equitable provision of quality maternal and neonatal health services

Lead agency: This output will be led by FHD, with support from the Logistics Division, Management Division, National Health Training Centre (NHTC), NHEICC, CHD, hospitals and PHCCs, concerned line ministries, external development partners and relevant professional organisations.

Background

The aim of Output 2 is to make quality essential SMNH services equitably accessible for all women and their newborns, through functioning and well-managed public health facilities that provide services at all levels (from tertiary referral hospitals to community based outreach services) and are linked through effective referral services. Essential SMNH services include: focused antenatal care; skilled attendance at birth; newborn care; post-natal care, including family planning services; Basic and Comprehensive Emergency Obstetric Care (B/CEOC), including post-abortion care; comprehensive abortion care; and effective referral services. Close linkages will be established with Output 1, Equity and Access activities in order to meet the needs of poor and socially excluded populations. Decentralisation of responsibilities to district and community levels and development of appropriate public/private partnerships will be key strategies in planning and programming. Professional organisations, such as the Nepal Society for Obstetricians and Gynaecologists (NESOG), Nursing Association of Nepal (NAN), Nepal Medical Association and Nepal Medical Council (NMC), will be important partners, and linkages with other reproductive health related initiatives will be developed as appropriate.

Advocacy efforts, through community level health service providers, will focus particularly on the importance of skilled birth attendance and healthy practices for mothers and newborns. At policy level, evidence based lobbying techniques will be used to influence decision-makers in addressing issues related to equitable access to quality SMNH services for all women, particularly those in remote and disadvantaged areas.

Activity Areas**A. Strengthening and expansion of quality SMNH services**

A strategy will be developed and implemented for the phased strengthening and expansion of quality SMNH services at all levels (especially the number and quality of B/CEOC sites and birthing centres), including monitoring of services with five-yearly reviews.

It is recognised that the majority of women still give birth at home and are not able to travel to health facilities for delivery or other essential SMNH services, and this will continue to be the case for some time. It is therefore essential to ensure that SMNH care is available at community level through home visits and outreach clinics, and appropriate health posts and sub health posts are developed as effective local facilities, with support provided for community level initiatives.

B. Linkages and integration with other reproductive health initiatives

To ensure the provision of complete SMNH services for all women and their newborns, neonatal care, family planning services, CAC, PMTCT and malaria treatment will be integrated with safe motherhood services through the development of improved linkages between relevant government ministries, divisions and programmes (the Female Community Health Volunteer (FCHV), Family Planning, HIV/AIDS and Malaria programmes) and appropriate external development partners. Close links will also be maintained with health related IEC/BCC activities

under the NHEICC (Output 1, Equity and Access). Joint planning, implementation and monitoring of activities at all levels will be promoted.

C. Quality of services

The quality of care provided in health facilities (including private and NGO) and at community level will be improved through a range of interventions that focus on development and implementation of national standards, training and capacity building for staff and community workers, effective monitoring and support systems with on site coaching and development of an enabling environment to support staff and community volunteers in their work. Institutionalisation of monitoring will be addressed through local quality of care teams.

D. Enabling environment

The development of an enabling environment that encourages health workers at all levels to strive for high standards and take responsibility for the services they provide will be promoted through: evidence-based lobbying for appropriate policies and programmes; improving logistic support, infrastructure quality and human resource deployment; supporting and capacity building local health management committees; encouraging socially inclusive local participation in health facility management; and promoting the concepts of accountability and the pursuit of excellence. Links with the SBA policy and programme will be improved.

E. Poor and socially excluded groups

Socially and economically excluded groups are also the hardest to reach because, in addition to their poverty and low education levels, they often live in areas that are geographically remote and/or severely affected by the armed conflict. These groups will be identified through equity and access programmes and community based volunteers and organisations, and innovative approaches used to prioritise them in planning appropriate SMNH activities, such as cost sharing and subsidy systems, which increase their access to services. The use of facilities by socially excluded groups will be monitored and the results used in programme planning (linked with Output 1, Equity and Access).

F. Referral systems

When complications occur, an effective referral system is essential to enable women and their newborns to receive appropriate and high quality emergency care as quickly as possible. At service level, efforts to improve the effectiveness of the system will focus on ensuring 24-hour availability of skilled staff with essential drugs and equipment, good community and inter-facility linkages and feedback systems to promote further improvements. Remote areas present an even greater challenge and require additional focused efforts, which will be covered by district specific strategies.

Output 3: Public Private Partnership

Purpose: Increased participation of the private sector, NGOs, community based organisations and professional/academic institutions in SMNH related public services to ensure consumers have equitable access to affordable services.

Lead agency: This output in relation to SMNH will be led by Department of Health Services with the shared responsibilities of Family Health Division and Child Health Division (for SMNH services), Management Division (regulation, and information) and National Health Training Centre (for trainings) Other support Agencies will include: Federation of Nepal Chamber of Commerce and Industries (FNCCI), the Organisation of Private Hospitals and Nursing Homes, Universities and the NGO Coordination Committee (NGOCC).

Background

In recognition of the limitations posed by financial and human resource constraints within the public health sector, the government is actively promoting the formation of new partnerships between the public and private or NGO sectors and professional/academic institutions, in order to ensure the provision of the widest possible choice of high quality health services and effective human resource development. In this way a range of different skills and resources can be made available to support government efforts to improve the health status of women and their newborns across the country. Public private partnership is a cross cutting approach, which can contribute to all other outputs in this plan.

Activity areas

Despite the stated policy promoting public private partnerships within the health sector, the lack of appropriate legal regulatory frameworks and guidelines means there has been little discernable progress. This is particularly important to ensure partnerships are able to contribute to increased SMNH service provision and access for poor and socially excluded groups, who will be a key target. Activities for this output will therefore focus on mainstreaming public private partnership initiatives at both policy and implementation level through the establishment of a representative regulatory body at MoHP. Appropriate legal frameworks and protocols will be developed and mechanisms for joint planning and monitoring established. District level institutions will be encouraged to identify and establish local partnerships.

Output 4: Decentralisation

Purpose: Enhanced local government and partner capacity to plan and oversee SMNH services in line with the Local Self Governance Act (LSGA).

Lead agency: This output will be led by the Policy, Planning and International Cooperation Division (PPICD) of MoHP. Other support agencies include the Ministry of Local Development and the District and Village Development Committee Federations.

Background

Since most people access health services at local level, devolution of decision-making and promotion of local accountability is the most effective way of ensuring that high quality services are available and accessible when needed for all sectors of society. This requires the active involvement of local communities and enhanced capacity of responsible local institutions, combined with effective communication and information sharing. Decentralisation is a cross cutting issue, with the potential to positively contribute to all other outputs in this plan, but its achievement will rely heavily on the overall decentralisation of health services.

Activity areas

The current decentralisation policy is expected to enhance the participation of local stakeholders in SMNH service provision and monitoring and increase equitable access to these services. The activities of this output will aim to clarify the roles and responsibilities of stakeholders in local level SMNH service provision, raise public awareness of the devolution of services and facilitate information sharing to promote public accountability and coordination at all levels. Capacity building will be provided for local institutions and line agencies to ensure maximum efficiency. There will be a particular focus on issues relating to poor and socially excluded groups.

Output 5: Human Resource Development: Skilled Birth Attendant Strategy

Purpose: Strategy/plan for human resource development in safe motherhood and neonatal health, particularly skilled birth attendant training, developed and implemented.

Lead agencies: This output will be lead by NHTC and MoHP. Support will be provided by the Human Resource Development/Skilled Birth Attendant forum, which has representation from FHD, Nepal Nursing Council (NNC), NMC, NAN, NESOG, JHPIEGO, WHO, UNFPA, Support to the Safe Motherhood Programme (SSMP), Institute of Medicine (IoM), Council for Technical Education and Vocational Training (CTEVT) and other key stakeholders involved in human resources development.

Background

Global evidence shows that skilled attendance during childbirth is a critical factor in saving the lives of mothers and their newborns. National human resource development efforts in SMNH are therefore focusing on increasing the number of health care providers competent to provide skilled birth attendance across Nepal and ensuring they possess the internationally defined set of skills required for a skilled birth attendant. In order to promote service availability for poor and socially excluded groups, efforts will be made to support the training of women from minority groups and remote areas and encourage them to serve their communities. Other health workers, such as health assistants and auxiliary health workers, who also play a key role at local level in saving the lives of mothers and newborns will be trained and encouraged to provide obstetric first aid. All training curricula will incorporate client friendly and gender sensitive approaches in order to promote an enabling environment for women to access SMNH services. Human resource development needs to be combined with upgrading of Health infrastructure, provision of equipments and supplies to ensure quality service delivery, and for this links will be made with Output 7, Physical Assets and Procurement. Public private partnership approaches (link with Output 3) will also be explored for contracting out of human resource development retention where appropriate.

Activity areas

A. Human Resource Development Plan

NHTC will take a lead role in developing an up coming Periodic Human Resource Development Plan to support National Periodic Plan. The aim of this plan will be to ensure 24-hour availability of SBAs, with required human resource mix for quality SMNH services. The plan will also look at broader human resource management related issues including geographical considerations for deployment, retention and career advancement of staff. The plan will also encourage health facility management committees to recruit the required number of staff, including SBAs, to deal with the increased number of births and the demands for other reproductive health services and ensure continuum of care. Appropriate human resource for anaesthesia will be developed for CEOC services.

B. Skilled Birth Attendant Development Strategy

The SBA Development Strategy will identify, upgrade and accredit SBA training sites in order to produce the required number of SBAs as quickly as possible. A public-private-community partnership approach will be promoted to identify potential SBAs, support their training, deploy and retain them through the creation of an enabling environment for them in the community. The Nepal Medical Council and

Nursing Council will approve an updated SBA training package (in-service and pre-service) in order to formalise the accreditation and licensing of SBAs. Special consideration will be given to recruiting and training health workers from the poor and socially excluded groups. Upgrading the skills of medical graduates (MBBS) for caesarean section will be done considering the importance and availability of CEOC services at district level.

Output 6: Information Management

Purpose: A comprehensive sector wide SMNH information base developed, incorporated and utilised within the Health Information System to support policy, planning, monitoring, evaluation and advocacy at national and local levels.

Lead agencies: This output will be led by the Health Management Information System (HMIS) Section working with the Management Division and FHD of the DoHS and with support from the PPICD and Monitoring and Evaluation Division of the MoHP.

Background

The HMIS provides an essential link in the work of all other divisions and sections within the DoHS and MoHP and other stakeholders in the health sector. The information stored underpins and supports all the other outputs within this plan, and forms basis for developing an understanding of cross cutting issues, such as ethnicity, caste, poverty and the effects of the armed conflict. In order to play this vital role effectively, the database needs to be comprehensive in its coverage, well managed and accessible, with reliable and accurate information collected from a range of sources, such as facility based data, surveys and other research. It is also important to ensure that this resource is known about so that it can be utilised to support advocacy efforts and ensure key issues and linkages are identified.

Activity areas

A. Information Management Strategy

An Information Management Strategy for SMNH will be developed to improve the collection of and access to reliable SMNH related data, and its use in evidence-based policy making, planning and advocacy work.

B. Data collection and quality

Through the HMIS and/or surveys, health and service utilisation data will be collected and analysed in relation to ethnicity, cast and wealth. To supplement quantitative data, additional information will be collected through qualitative studies using a range of different tools, such as key informant monitoring. Exercises to verify data and increase its reliability will be designed and implemented. Information will be collected for maternal and newborn deaths from health institutions in collaboration with FCHVs.

C. Access to information

Efforts will be made to ensure that information is available to stakeholders at all levels, including within communities, and orientation and capacity building will be provided to increase their understanding of key SMNH issues. Public private partnerships and relationships will be explored to increase the flow of information both to and from HMIS.

D. Monitoring

The quality of monitoring will be improved through the provision of training in SMNH programme monitoring approaches. New and innovative monitoring tools, such as key informant monitoring, will be designed and implemented as appropriate. Strengthening of monitoring SMNH services at health institution level will be initiated.

Output 7: Physical Assets and Procurement

Purpose: Adequate physical resources for SMNH services with year round availability of MNH related drugs and supplies.

Lead agency: This output will be led by the Director General of the DoHS and Regional Health Directorates (RHD).

Background

Availability of and access to high quality SMNH services is strongly dependent on the provision of adequate physical resources and infrastructure, which also impacts on staff morale and performance and on public perceptions of quality of service. Output 7 is therefore an important pillar on which other efforts rest. In the past there have been shortcomings in both infrastructural development/maintenance and in the management of resources and essential supplies. This will be addressed through the establishment of improved systems for planning, monitoring and record keeping, and development of appropriate linkages with other relevant outputs and stakeholders.

Activity areas

A. Inventory of MNH facilities and equipment

An inventory of all government health facilities, by district, will be prepared, including zonal, regional and district hospitals, Primary Health Care Centres (PHCC), Health Posts and Sub Health Posts (SHP). Details of land ownership, age of buildings, type of construction and area, existing condition and available support services will be recorded. A separate equipment inventory, stating the type, quantity and condition of equipment, will be prepared for each facility.

B. Development, renovation and maintenance of physical resources

Selection of sites for infrastructure development and upgrading will be need based rather than resource based, taking into account equity and efficiency concerns and using agreed and approved criteria. Priority will be given to upgrading SHPs to birthing centres in order to promote community level service availability. All physical resources development work will be closely linked with Output 5, Human Resource Development.

A building and equipment maintenance policy will be developed, with coordination between the DoHS and the Department of Urban Development and Building Construction (DUDBC) and support from external development partners. This will guide the annual plan for infrastructure development and equipment.

C. Planning, implementation and quality assurance

Need assessment, planning, design and implementation of health facility improvements will be carried out in consultation with users and other stakeholders, including inputs from expert advisers. Regular monitoring will be included in the process through a monitoring committee comprising representatives from relevant government divisions, external development partners, users and other stakeholders, chaired by the Director General, DoHS to assure quality of construction and equipment.

Quality assurance procedures and compliance testing of drugs (through DDA, LMD and private laboratories) will be strengthened. Commodity distribution will be improved through decentralised decision-making and strengthened management systems. Where possible, commodities will be delivered directly to sites, rather than through central stores.

A joint planning mechanism between FHD, LMD and CHD will be developed for equipment, drug and commodity procurement planning, implementation and monitoring. A similar joint planning mechanism between MoHP, Ministry of Planning and Physical Works (MPPW) and MD will be developed for infrastructure development and maintenance work. Procurement mechanisms will be improved by reforming MoHP procurement policies and capacity building at local and central levels.

D. Database, protocols and distribution channels for drugs and commodities

A national level database of SMNH drug suppliers will be prepared, incorporating distribution channels such as means of transportation and storage facilities. The authority for purchasing commodities will be transferred to districts (where private suppliers can guarantee price and availability) while maintaining nationally negotiated prices, both for government and sanctioned NGO and external development partner facilities. This will gradually reduce the need for LMD to distribute drugs to districts.

In order to improve resource utilisation and information systems available to decision-makers, the Logistics Management Information System (LMIS) will be strengthened through selective decentralisation of data processing to the district level, inclusion of all SMNH commodities in the LMIS and a review of reporting mechanisms.

Rational use of drugs will be promoted through the use of the SMNH treatment protocol and drug financing schemes will be supported, linked with Outputs 2 and 8 respectively.

Output 8:	Finance
Purpose:	Sustainable financing system improved for Safe Motherhood and Neonatal Health Services.
Lead agency:	This output will be led by the Health Economics and Financing Unit (HEFU), of the MoHP.

Background

The emphasis of this output is on establishing a system to support a sustainable financing base for SMNH activities. This includes identifying and mobilising financial resources, ensuring their effective utilisation, looking at innovative approaches to financing, particularly at local level, and encouraging users and other partners to develop supportive linkages that may include financing or other cost saving inputs. Where possible, initiatives promoting self sufficiency will be promoted, but specific systems will be put in place to ensure the needs of poor and socially excluded groups are catered for.

Activity areas

A. Increasing and mobilising resources for SMNH

With assistance from the health sector support programme, financial resource gaps will be identified, and the evidence used for lobbying and advocacy to increase resource allocation for SMNH (linked with Outputs 1 and 6, Equity Access and Information respectively). Resource allocation formula, capacity building/training and financial management information systems will be improved through the collaborative efforts of HEFU the Finance Section DoHS, and HMIS. The private sector (both for profit and not for profit) will be encouraged to increase inputs to MNH services (linked with Output 3, Public Private Partnerships), under appropriate regulation. The cost-sharing scheme will be implemented and promoted with the active participation of local bodies, civil society, and NGOs.

B. Promoting alternative financing schemes

The community health insurance scheme developed under the health sector support programme, which includes safe delivery and emergency obstetric and neonatal care services, will be expanded, and health cooperatives will be promoted with the collaboration of HEFU, Management Division and FHD. Alternative financing schemes will be promoted, such as revolving community emergency funds to increase access to services for maternal and neonatal emergency cases (linked with Output 1, Equity Access). District based external development partner programmes, community organisations and other local bodies will facilitate and monitor emergency funds with the support of MoHP, Ministry of Local Development (MoLD), and Ministry of Women Children and Social Welfare.

C. Safety net for poor and socially excluded groups

Systems are necessary to protect poor and socially excluded groups and ensure their ability to access services. Mechanisms to achieve this will be further developed and improved, working with the health sector support programme to test new mechanisms of financing (linked with Output 1, Equity Access). MoHP will provide guidelines regarding user fees and safety net arrangements for poor mothers and their newborns. The DoHS will monitor implementation, with support from the Regional and District Health Offices (link with Output 2, Services).

Explanatory notes

Basic Emergency Obstetric Care

This includes, administering parental antibiotics, oxytocic drugs and anticonvulsants, performing manual removal of placenta, use of manual vacuum aspiration and assist vaginal delivery with vacuum /forceps

Comprehensive Emergency Obstetric Care

This includes all the six components of BEOC and provision of surgery (caesarean section) and blood transfusion.

Essential SMNH services

These include: focused antenatal care; skilled attendance at birth; newborn care; post-natal care, including family planning services; Basic and Comprehensive Emergency Obstetric Care (B/CEOC), including post-abortion care; comprehensive abortion care; and effective referral services.

Definition of skilled birth attendant (SBA)

“An accredited health professional-such as a midwife, doctor or nurse-who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the postnatal period and in the identification, management and referral of complications in women and newborns (WHO)

Chapter 3: Logframe



Logframe: Revision of National Safe Motherhood and Newborn Health Long Term Health Plan (NSMNH-LTP 2006-2017)

Hierarchy of Objectives	Indicators	Means of Verification	Assumptions/Risks
<p>Goal</p> <p>Improved maternal and neonatal health and survival especially of the poor and vulnerable</p>	<p>1. Maternal mortality ratio reduced: 2007: 300 per 100,000 2012: 240 per 100,000 2017: 134 per 100,000</p> <p>2. Neonatal mortality ratio reduced: 2007: 32 per 1,000 live births 2012: 20 per 1,000 live births 2017: 15 per 1,000 live births</p>	<p>DHS CBS Data Census</p>	
<p>Purpose</p> <p>Increased healthy practices and utilisation of quality maternal and neonatal health services, especially by the poor and vulnerable, delivered by a well managed health sector</p>	<p>1. Percentage of deliveries conducted by SBAS 2007: 20% 2012: 40% 2017: 60%</p> <p>2. Percentage of deliveries in a health facility 2007: 20% 2012: 30% 2017: 40%</p> <p>3. Increase in met need for EOC of 3 % each year</p> <p>4. Increase in met need for caesarean section of 4% each year (Indicators 1-4 will also be disaggregated by poor and socially excluded)</p>	<p>DHS NLSS/Annual Report of DoHS</p> <p>NLSS/Annual Report of DHS HMIS</p> <p>HMIS/DHS EOC Monitoring Report HMIS EOC Monitoring Report <i>Baseline disaggregated data to be drawn from DHS</i></p>	<ul style="list-style-type: none"> Political situation remains stable and peaceful DDCs and VDCs are elected and functional Strong political commitment to safe motherhood Overall environment (social, political and economic) is stable
<p>Outputs</p> <p>1. Equity and Access Individuals, groups and networks socially</p>	<p>1.1 Knowledge about maternal and neonatal danger signs among men and women of</p>	<ul style="list-style-type: none"> DHS 	<ul style="list-style-type: none"> SMNH continues to be a high priority in an

<p>empowered to practise desired SMNH behaviours leading to increased equity of, and access to health services.</p> <p><i>(Social empowerment includes improving knowledge attitudes, behaviours, confidence, legal and social status and access to resources, including transport and finance schemes, of individuals, groups and networks)</i></p>	<p>reproductive age, including disadvantaged groups, increased to 80% by 2017.</p> <p>1.2 Men and women of reproductive age, including disadvantaged groups, able to identify B/CEOC sites and SBAs increased to 80% by 2017</p> <p>1.3 Desired change in targeted KAP among men and women of reproductive age (related to focused ANC, PNC EOC, ENC, PAC and CAC)¹</p> <p>1.4 Percentage of people practising birth preparedness and complication readiness increased to 70% by 2017</p> <p>1.5 Communities (wards) having sustainable emergency funds and transportation schemes increased to 70% by 2017</p>	<ul style="list-style-type: none"> • Periodic surveys both qualitative and quantitative • HMIS • DHS • DoHS annual report <p>National KAP Survey²</p>	<p>emerging sector wide framework even after 2009</p> <ul style="list-style-type: none"> • Harmonisation and coordination among SMNH stakeholders
<p>2. Services</p> <p>Enhanced and equitable provision of quality SNMH services</p> <p><i>(Essential SMNH services include: focused ANC, delivery by skilled birth attendant with newborn care, PNC, EOC, CAC services and referral services)</i></p>	<p>2.1 Percentage of HPs providing normal delivery services and newborn care in line with national standards</p> <p>2007: 10%</p> <p>2009: 15%</p> <p>2012: 30%</p> <p>2017: 70%</p> <p>2.2 Percentage of PHCCs providing BEOC, including newborn care and CAC services. (Baseline: 9% in 2004/5)</p> <p>2007: 20%</p> <p>2009: 40%</p> <p>2012: 60%</p> <p>2017: 80%</p> <p>2.3 Number of districts providing CEOC, newborn care and CAC services (including private sector) (Baseline: 26 in 2004/5)</p> <p>2007: 31</p> <p>2009: 37</p> <p>2012: 47</p>	<ul style="list-style-type: none"> • Administrative records • Periodic supervision reports • HMIS • DHS • DoHS annual reports • FHD records • Study/Survey reports 	<ul style="list-style-type: none"> ▪ Continuing political commitment and resources for safe motherhood as a priority ▪ Commitment and resources for local capacity building in health management as a part of decentralisation efforts ▪ Development of safe and effective ways of working in conflict-affected areas

¹ Specific indicators related to the indicators are: **ANC** - % of pregnant women who receive 4 focused ANC checkups (with TT, iron supplementation, de-worming and counselling for danger signs); **EOC** – knowledge of danger signs, identification of local SBA and where to go in case of emergency; **PNC** - % of women who receive at least 3 focused PNC checkups (iron supplementation, vitamin A, counselling for danger signs and contraceptive services); **ENC** - % of postnatal women who know to wait for at least 24 hours to bathe their newborn and to keep it wrapped and warm; **PAC** - % acceptance of post procedure contraception; **CAC**- % of women who know legal conditions for safe abortion and where to go for services.

² National KAP Survey 2006, NHIECC

	<p>2017: 60 2.4 CAC services available in all district hospitals by 2009</p>		
<p>3. Public Private Partnership Increased participation of private sector, NGOs, CBOs and professional / academic institutions in public services (SMNH related) which ensures consumers have equitable access to affordable services.</p>	<p>3.1 Number of SMNH services, human resource development and access related contracts with NGOs, CBOs, professional/academic institutions and private sector increased 3.2 Strategic plan and implementation guidelines on PPP jointly developed and endorsed by the MoHP by the end of 2007 3.3 Private, NGO, CBO sectors and professional / academic institutions with SMNH services increased by 20 percent by the year 2017.</p>	<ul style="list-style-type: none"> DoHS Annual Report Plan and guidelines on PPP DoHS Annual Report 	<ul style="list-style-type: none"> Conducive policy environment for partnership with NGO, CBO and private sector continues
<p>4. Decentralisation Enhanced local government and partner capacity to plan and oversee SMNH services in line with Local Self Governance Act</p>	<p>4.1 Annual health plans developed by DDCs that cover SMNH and social inclusion, and involve local stakeholders 4.2 Increased share of SMNH from 5% to 8% of district annual budget</p>	<ul style="list-style-type: none"> Annual health plans DDC plan District budget 	<ul style="list-style-type: none"> Conducive policy environment on decentralisation Strong policy and financial commitments from government, EDPs Priority given to SMNH and social inclusion by local bodies continues Local bodies remain responsive to local voices
<p>5. Human Resource Development: Skilled Birth Attendant Strategy Strategy/Plan for Human Resource Development in relation to SMNH and for Skilled Birth Attendants developed and implemented</p>	<p>5.1 HRD strategy/plan for SMNH (2007-2012) developed, incorporated in next periodic Health Plan and implemented 5.2 Health facilities (District and PHCC) fully staffed by SBAs (with skill mix, both number and types): 2007: 25% 2012: 50% 2017: 80%</p>	<ul style="list-style-type: none"> Training report from accredited training sites by NNC 11th Five year Health Plan HURIC data HURIC, TMIS and MoHP data 	<ul style="list-style-type: none"> SMNH HRD strategy /plan reflected in the 11th Five Year Plan
<p>6. Information Key SMNH related information, including</p>	<p>6.1 95 percent of public and 25% health institutions of private sectors and NGOs report their SMNH service data to HMIS by</p>	<ul style="list-style-type: none"> HMIS DHS DoHS annual report 	

<p>disaggregation by ethnicity, caste and wealth, developed, incorporated within the HMIS, and other sources of information (NDHS, NLSS etc) used at national and local levels</p>	<p>2008, 50% by 2012, and 100% by 2017 6.2 Disaggregated SMNH data generated by 2008 6.3 Use NDHS, NLSS surveys information in planning and policy formulation process.</p>		
<p>7. Physical Assets and Procurement Adequate physical resources for SMNH services with year round availability of SMNH related drugs and supplies ensured</p>	<p>7.1 Number of districts with at least one fully equipped CEOC facilities increased from 28 to 31 by end of 2007 and to 60 districts by end of 2017 7.2 Percentage of PHCCs with fully equipped BEOC facilities increased from 9% to 20% 2007 and 40 % by the year 2009, 60 % by the year 2012 and 80% by 2017 7.3 HPs with birthing centres 2007: 10% 2009: 15% 2012: 30% 2017: 70% 7.4 Year round availability of SMNH drugs and commodities increased to 100% by 2012 7.5 Drug financing schemes implemented as stated in NHSP-IP (8)</p>	<ul style="list-style-type: none"> DoHS annual report LMIS Report 	<ul style="list-style-type: none"> Financial support from EDPs continues
<p>8. Finance Sustainable financing system for SMNH services improved</p>	<p>8.1 At least 15% of public expenditure on health spent for SMNH at the end of 2012 from 10% and 20% by 2017 8.2 At least 45% of SMNH public expenditure will be spent for the benefit of disadvantaged groups³ by 2012 and 50% by the 2017 8.3 At least 45% of the women benefiting from the cost sharing scheme will be from disadvantaged groups (Dalit and Janjati) by 2012 and 50% by 2017 8.4 At least 50% of villages will have functional revolving SMNH emergency funds by 2012 and 60% by 2017.</p>	<ul style="list-style-type: none"> Survey report FMIS LSI Monitoring /Assessment reports NLSS LSI Monitoring /Assessment reports Annual report DoHS 	<ul style="list-style-type: none"> SMNH share of health budget increased as planned Local bodies are functional Level of resources remains the same as planned

³ Specifically this includes Dalits (low caste or occupational caste) and Janjatis (ethnic minority groups)

Major Activity Areas	Assumptions
<p>1. Equity and Access</p> <p>A. Advocacy</p> <ol style="list-style-type: none"> Lobby policy makers and influential people at national, district and community levels, incorporating user and provider voice, to have appropriate policies in place for social empowerment of women, families and communities (including protection, security, rights, ending discrimination, improving status) Lobby at all levels for equitable distribution of services and infrastructure, including roads, bridges and one functioning telephone in each facility <p>B. Social Mobilisation</p> <ol style="list-style-type: none"> Involve communities in participatory planning, including conducting social mapping, implementing, monitoring (including voice) of SMNH programmes and taking a community-based localised approach. Women and men should be involved especially women of reproductive age, mothers-in-law and influential family members, and displaced women and their families included Mobilise health workers, traditional health care providers, local media, youth groups, community volunteers/FCHVs, private practitioners, mothers' groups, school teachers, local representatives and duty holders (from schools, forest and water user and savings and credit) groups to promote SMNH Provide support to strengthen coordination forums (RHCC/SMNF/SMNSC/ and sub-committees) at all levels to implement SMNH programmes, especially targeting the RH IEC technical committee Build communities' capacity to create and utilise sustainable emergency funds and transportation schemes (link with Output 2, Services) Promote cross-sectoral (inter and intra-ministerial, divisional, NGOs) collaboration for integrating SMNH <p>Behaviour Change Communication (BCC)</p> <ol style="list-style-type: none"> Conduct national baseline research Update and implement integrated safe motherhood and newborn health communications strategy, including standardising messages and making them available at all levels Develop and implement focused research based communication interventions (linked with service improvement) to reach disadvantaged and vulnerable groups including displaced people Promote SMNH related healthy behaviours, including birth preparedness, by conducting BCC activities and using rights based approaches, specifically reducing all violence against women Promote positive, non-discriminatory inter-personal communication between providers and clients 	<ul style="list-style-type: none"> Coordinated effort to implement the decentralisation act Communities willingly participate in SNMH programmes Conflict does not limit the mobility and gathering of people at district level and below Inter Ministry coordination supports establishment of functioning phone lines
<p>2. Services</p> <ol style="list-style-type: none"> Strengthen and expand quality SMNH services at all levels in a phased manner, including C/BEOC, delivery and CAC services, Improve linkages and integration with other reproductive health and child health initiatives (such as IMCI, PMTCT, Malaria, CAC, FCHV programmes) 	<ul style="list-style-type: none"> Resources continue to be available for improving physical facilities, maintaining adequate staffing and

<p>3. Improve the quality of services through development of quality assurance and monitoring systems with on-site coaching and logistic support, in coordination with appropriate divisions</p> <p>4. Create an enabling environment for SMNH services through advocacy at all levels, capacity building of local management bodies and involvement of civil society and private sector in coordination with appropriate divisions</p> <p>5. Prioritise the needs of poor and vulnerable groups, focusing on supporting community care in marginalized areas and developing strategies for reducing service costs for poor women</p> <p>6. Improve the functioning of referral systems by developing simple referral protocols, strengthening mechanisms, orienting community workers and ensuring 24-hour availability of services</p> <p>7. Avail anaesthesia service (See <i>Annex for more detailed activities</i>)</p>	<ul style="list-style-type: none"> ▪ providing support ▪ Other RH initiatives willing to cooperate ▪ Conflict does not limit activities ▪ Local Management bodies are committed to SMNH services
<p>3. Public Private Partnership</p> <ol style="list-style-type: none"> 1. Establish an effective regulatory body at MoHP with representation from the private sector, NGOs and CBOs 2. Develop a legal framework, protocols and guidelines to encourage and regulate PPP, including transfer of public resources to NGOs, CBOs and the private sector 3. Establish and strengthen joint annual planning and review mechanisms with representation from private sector, NGOs, CBOs support from experts 4. Include NGO, CBO and private sector SMNH plans and progress in health sector monitoring 5. Provide capacity building on SMNH service delivery for NGOs, CBOs and the private sector 6. Harmonise PPP procedures for implementation to ensure consistency with those of Government and EDPs 7. Enhance the capacity of district RHCCs to address service provision, equity and access and social inclusion issues in SMNH 8. Train doctors on C/S 	<ul style="list-style-type: none"> • Strong policy and financial commitment from Government, EDPs and private sector
<p>4. Decentralisation</p> <ol style="list-style-type: none"> 1. Ensure clarity about roles and responsibilities of stakeholders for delivering devolved SMNH services 2. Raise public awareness about devolution of SMNH services to community level 3. Facilitate quarterly public dissemination of SMNH budgets and amount spent 4. Strengthen management capacity at local level 5. Support district and facility level planning and monitoring related to SMNH, with focus on equity and access and social inclusion 6. Develop and implement a standard monitoring checklist for SMNH services, including equity and access and social inclusion issues 7. Establish a system of rewards and incentives for those providing efficient non-discriminatory SMNH services at local level 8. Track the outcome and impact of devolution on local SMNH indicators 9. Develop methods for greater public accountability of local health services 10. Increase transparency and public access to SMNH related information on: budget, spending, human resources, logistics, supplies, services available and provided and indicators 11. Enhance coordination among key bodies such as RHCC, DHMC, DACC, CDP and ISC. 	<ul style="list-style-type: none"> • Local bodies remain responsive to local voices • Maternal health remains a priority for the local bodies • Local government is accommodative in planning and monitoring

<p>5. Human Resource Development: Skilled Birth Attendants' Strategy/Plan</p> <p>A. Human Resource Strategy</p> <ol style="list-style-type: none"> 1. Develop a 5-year HRD strategy for SMNH services 2. Develop and maintain a database of human resources and skills their utilisation 3. Develop tools for undertaking post training onsite supervision and monitoring 4. Develop mechanisms for undertaking performance assessment of trained health care providers 5. Establish a national award system for "safe motherhood champion" in collaboration with professional organisations <p>B. Skilled Birth Attendants' Strategy</p> <ol style="list-style-type: none"> 1. Develop a 5-year SBA in-service training strategy/plan 2. Develop generic (27 core skills) competency based SBA training package 3. Review and develop accreditation standards for training institutions, scope of practices and certification standards for SBAs 4. Identify gaps in the existing BEOC in-service curriculum and adapt for in-service SBA training (ANMs, SN and MBBS) 5. Screen existing health care providers (ANMs, SNs and doctors) who have received MRT and BEOC to assess whether they require refresher training 6. Upgrade SBA training sites 7. Conduct planning meeting with 5 RHTCSs to make arrangements for beginning SBA training 8. Train service providers to ensure they have core SBA competencies and certify them 9. Adapt the generic package for pre-service training 10. Strengthen the capacity of pre-service training institutions (ANM, PCL) 11. Ensure all new ANM graduates have core SBA competencies and certify them 	<ul style="list-style-type: none"> • 11th Five year Health Plan approved by MoF, MoGA, Public Service Commission and National Planning Commission • Obstetric component of pre-service curriculum for MBBS updated • Sufficient number of ANM, PCL training sites accredited by NNC • Sufficient number of ANM graduates certified as SBAs by NNC
<p>6. Information Management</p> <p>A. Information management strategy</p> <ol style="list-style-type: none"> 1. Develop a strategy to incorporate key SMNH information within an integrated matrix (disaggregated by ethnicity, caste, and wealth) <p>B. Data collection and quality</p> <ol style="list-style-type: none"> 2. Improve the quality of data collected 3. Conduct data verification exercises 4. Design and implement research and studies for generating additional information that is not incorporated in HMIS <p>C. Access to Information</p> <ol style="list-style-type: none"> 5. Increase access to SMNH information at all levels (community to centre) 6. Build relationships with public, private and NGO sectors, and introduce mechanisms for regulating the flow of information to HMIS 7. Provide orientation to build capacity of SMNH stakeholders to generate understanding on SMNH issues at all levels (community to centre) 	<ul style="list-style-type: none"> • Comprehensive HMIS is feasible • A functional body is in place to regularly review and recommend change in HMIS to respond to programme needs

<p>D. Monitoring</p> <p>8. Provide training and refresher training on SMNH programme monitoring9. Design and implement Key Informant Monitoring system10. Design and implement conflict monitoring system</p>	<p>7. Physical Assets and Procurement</p> <ol style="list-style-type: none"> 1. Develop an inventory of SMNH service facilities, equipment and instruments 2. Implement a system for criteria based district selection for expansion/extension/renovation of physical facilities 3. Develop and implement need based participatory planning, monitoring and implementation mechanisms 4. Develop and implement a maintenance policy 5. Develop inter-ministerial and inter-departmental coordination mechanisms for physical resource and commodities planning, monitoring and implementation 6. Establish a database of suppliers and distribution channels for drugs and commodities 7. Strengthen the quarterly LMIS reporting system for consumption of SMNH related drugs and other commodities 8. Implement MNC treatment protocols with rationale use of drugs (refer to Output 2, Services) 	<ul style="list-style-type: none"> • Transport bottlenecks are not significantly increased • EDP commitment of funding support does not decline • Situation allows monitoring of physical facility construction • Conflict situation does not affect implementation activities
<p>2. Finance</p> <p>A. Increasing resources for SMNH</p> <ol style="list-style-type: none"> 1. Conduct evidence based advocacy to increase availability of financial resources for SMNH services 2. Redesign the resource allocation formula 3. Carry out capacity building/training for timely spending of available financial resources 4. Improve Financial Management Information System (in line with the NHSP-IP) 5. Implement and refine the cost sharing scheme 6. Develop and implement a sustainability plan <p>B. Promoting alternative financing schemes</p> <ol style="list-style-type: none"> 7. Conduct operational research on sustainable financing 8. Develop national guidelines and provide community matching for SMNH emergency funds <p>C. Safety net for poor and vulnerable groups</p> <ol style="list-style-type: none"> 9. Contribute to the user charge policy, adding exemption criteria for the most vulnerable groups 10. Monitor and evaluate financing schemes 	<ul style="list-style-type: none"> • Level of demand for health resources does not grow massively because of the conflict • All districts have functioning telephones • Insurance scheme expands as planned • Situation allows regular monitoring and evaluation 	

Annex 1: Detailed activities under major categories for services (Output 2)

2.1 Strengthen and expand quality SMNH services at all levels in a phased manner, including B/CEOC, delivery and CAC services

- a) Develop appropriate selection criteria for B/CEOC sites and birthing centres.
- b) Develop and implement a need based planning and monitoring system and a phased expansion plan for B/CEOC sites in district hospitals and PHCCs, and for birthing centres in appropriate HPs and SHPs, according to agreed criteria. The minimum requirement for CEOC and BEOC sites according to the UN standard is four BEOC sites and one CEOC site per 500,000 population. However, the sparse population distribution in the hill and mountain areas and associated poor transport availability means that Nepal may need more C/BEOC sites than specified by this criterion, or a strengthened referral system in those districts where CEOC services are not feasible or cost effective.
- c) Encourage the community, EDPs and private/NGO sector to develop delivery centres and EOC services (including essential newborn care) to complement government services and conform with national standards.
- d) Ensure skilled birth attendants are available at HPs and SHPs and in communities. Encourage women to use an SBA for home births if they are not able to go to a health facility (link with Outputs 1, Equity and Access, and 5, Human Resource Development).
- e) Encourage health workers to provide early PNC care (within 72 hrs of the birth) at home or in the health facility. Encourage FCHVs to provide postnatal home visits to advise new mothers and their families about caring for mother and baby, and link this with the FCHV programme to ensure mothers' groups are informed about the importance of PNC.
- f) Strengthen care for low birth weight and sick newborns in health facilities and in communities/ families.
- g) Strengthen postpartum family planning counselling and services (link with family planning services).
- h) Develop CAC services in all district hospitals and appropriate PHCCs, and encourage private/ NGO sectors to expand CAC services in line with the CAC policy.

2.2 Improve linkages and integration with other reproductive health and child health initiatives

- a) Newborn care:
 - Integrate essential newborn care in safe motherhood and child health care programmes at all levels in order to create synergy and maximise outputs.
 - Integrate neonatal care in the IMCI programme.
 - Link with Child Health Division to provide micronutrient supply and TT immunisation for pregnant women as part of ANC and PNC services.
 - Build linkages with IEC/BCC and access programmes to ensure information and services are matched.

- b) HIV/AIDS: Link with NCASC to provide PMTCT and care of HIV positive pregnant women in selected high risk districts according to the HIV/AIDS policy and programme.
- c) Malaria: Provide anti-malarial treatment to pregnant women in endemic areas, according to national standards, through linking with the malaria section of the Epidemiology Division.

2.3 Improve quality of services through development of quality assurance and monitoring systems with on-site coaching and logistic support, in coordination with appropriate divisions

- a) Coordinate with Management Division to develop and implement a comprehensive quality assurance system for safe motherhood and newborn care, covering all levels and including private/NGO sectors:
 - Develop/update and implement SMNH Standards, protocols guidelines and tools for maternal and newborn care at all levels of service.
 - Work with Management Division to develop quality of care monitoring teams at central, regional and district levels for technical and management supervision.
 - Develop the capacity of district health management committees, health service providers and public health nurses and institutionalise quality assurance, in line with quality monitoring guidelines.
 - Support the inclusion of the private/NGO sector under the national system for quality assurance, to encourage them to adopt national standards and QOC guidelines.
 - Ensure sufficient logistic support is available (link with output 7, procurement).
- b) Develop, plan and implement regular monitoring and supervision systems at different levels:
 - Institutionalise the EOC monitoring system in HMIS and in safe motherhood districts including private/NGO sector facilities.
 - Increase the capacity of public health nurses/ district supervisors to provide effective monitoring and supervision and on-site coaching.
 - Develop supervision checklists and guidelines.
- c) Implement and expand maternal and peri-natal death audits in hospitals in a phased manner, according to guidelines and involving professional organisations such as NESOG, NEPAS, PESON and NAN.
- d) Carry out periodic assessment and research in the field of SMNH, including community perception of quality of care through use of techniques such as client exit interviews and interaction with communities, in order to improve policy development and programming.

2.4 Create an enabling environment for SMNH services through advocacy at all levels, capacity building of local management bodies and involvement of civil society and private sector in coordination with appropriate divisions

- a) Advocate and lobby at all levels for appropriate need based SMNH policies, programmes and resource allocation, to ensure the availability of quality SMNH services and respond to local realities (link with Output 1, Equity and Access).

- b) Coordinate with Management Division to strengthen the capacity of local health management committees, coordination forums and communities influential in the management of SMNH services at different levels of health facility, as part of the decentralisation effort. Ensure the participation of civil society, NGO/ private sectors and Dalit and Janjati groups in the process.
- c) Develop mechanisms to promote accountability and team spirit in health facility management committees and staff for the delivery of quality SMNH services, using appreciative and participatory management processes and involving communities and civil society.
- d) Work with NHTC to ensure adequate human resources are in place nurses are legally protected when dealing with emergencies in outlying areas (link with output 5, human resource development).
- e) Work with Logistics Management Division to develop essential SMNH related drugs and equipment lists and make them available (link with Output 7, Physical Assets and Procurement).
- f) Develop infrastructure standards for SMNH services (link with Output 7, Physical Assets and Procurement).
- g) Empower female staff in health institutions as change agents, through on-site support, leadership and management training. Increase their participation in planning programming, decision-making and supervision.

2.5 Prioritise the needs of poor and vulnerable groups, focusing on supporting community care in marginalized areas and developing strategies for reducing service costs for poor women

- a) Prioritise and target health facilities which provide SMNH services for poor and vulnerable groups.
- b) Develop a strategy for reducing the cost of delivery and EOC that ensures key services are affordable (costs are transparent, including rational protocols for drugs), and subsidies are available for poor people.
- c) Ensure that the cost-sharing scheme, which aims to encourage all women to use an SBA for childbirth, is known about and accessible to poor and vulnerable women (link with Output 1, Equity and Access).
- d) Monitor utilisation of SMNH services by vulnerable groups to gain a better understanding of what works, and apply these lessons to programming.

2.6 Improve the functioning of referral systems by developing simple referral protocols, strengthening mechanisms, orienting community workers and ensuring 24-hour availability of services

- a) Strengthen the responsiveness of referral mechanisms.
- b) Establish linkages between health facilities, peripheral health care providers and volunteers, traditional practitioners and NGO/CBO coordination forums.
- c) Develop a referral protocol (including conditions for patients to be referred and stabilisation with obstetric first aid before and during transport) and slip, with mechanisms for communicating with higher centres and links with emergency funds and transport schemes to assist in referral of poor women (link with Output 1, Equity and Access).
- d) Develop a special strategy for remote districts and conflict affected areas, such as establishment of maternity waiting homes near referral hospitals for pregnant women who are near term.
- e) Develop and pilot maternity waiting home operational guidelines.
- f) Develop a safety net and subsidy system for poor women (link with Output 8, Finance).

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