

Safe Motherhood Programme in Nepal

In Nepal, MMR (Maternal Mortality Rate) is estimated at 539/ 100,000 live births (1996 NFH Survey), which is unacceptably high. It has been estimated that a woman dies every two hours from pregnancy related causes. For every maternal death it is estimated that another 30-40 women suffer from disabilities.

The major factors for the high maternal deaths include the overall poor health of women and lack of access to quality maternal health care services, particularly in rural areas and difficult terrains, and poorly developed transportation and communication systems.

Over 70% of pregnant women suffer from nutritional anaemia. While fertility rate has declined over the past decade, it is still high at 4.1. Teenage marriages and pregnancies are also high. 50% of girls aged 15-19 years are married and 24% are already pregnant or with their first child (NFHS 1996). The maternal mortality morbidity (MMM) study has shown that a significant proportion of maternal deaths (18.6%) occurred among adolescents.

The 1991 NFH Survey indicated that only 18% of women received antenatal care; delivery by trained health workers was as low as 1.9%; TT2 coverage was only 16% and the CPR 24%. Thus viewing maternal and neonatal mortality as a major challenge, the Ministry of Health endorsed "Safe Motherhood" as a priority in its 1991 Health Policy.

With the launching of the Safe Motherhood Programme there has been some progress in the coverage of maternity care services. ANC coverage has increased to 49%; delivery by trained health workers to 13%; PNC by health

workers to 17%, TT2 coverage 45% and CPR has increased to 39% (DHS Survey, 2001).

WHO has supported the SMI programme since its very inception. In 1993 with WHO support the "National SM Plan of Action (1994-97)" was prepared. SM Programme Policy and strategies including intervention guidelines were developed and implementation of the programme launched in 1997.

In 1998, the Family Health Division formulated the "National Reproductive Health Strategy" with SM as the main vehicle for addressing Reproductive Health issues.

The Government and its SM programme partners - including UNICEF, UNFPA, USAID, DFID, GTZ and WHO, developed National Maternity Care Guidelines, Standards of Midwifery Practice Based on SEARO/Standards, SM Clinical Protocols and Management Guidelines, the National SM/IEC and National SM Training Strategies, QOC Strategy for Maternal Health Care and National Strategy for Control of Anaemia among Women and Children in Nepal.

Community mobilization tools such as the Birth Preparedness Package (BPP) and a Behavioral Communication Change (BCC) package have also been prepared and are being implemented.

A community-based MMM study conducted in 1997-98 revealed that 67% of maternal deaths occur at home, 11% died on the way to a health facility and 21% at a health facility.

The study also provided valuable information on the three delays, that contribute to maternal deaths. It also highlighted the need for community-based interventions to overcome the first two delays. Recognizing that every pregnancy is at risk, the following strategies have been adopted:

- Provision of around the clock emergency obstetric care services;
- Ensuring the presence of skilled attendants at birth; and
- Enhancing public awareness on SM issues through community mobilization, empowering of community, family and women.

Ongoing efforts address barriers to care such as gender, social dynamics that affect decision making about care, educating mothers and communities about proper care during pregnancy and delivery, and equipping them to identify obstetric danger signs and to seek timely care. In addition,



Training of staff is an important element of the Safe Motherhood Programme.

health facilities at the district level are being improved to provide quality midwifery and essential obstetric care services.

In 1997 hospitals in three selected SM districts were upgraded as the first referral units to provide around the clock CEOC services. The model is being expanded in thirteen additional districts supported by DFID and UNICEF.

A 15-year SM Plan of Action was developed by FHD in 2001. The long-term goal of the plan envisages establishment of BEOC and CEOC services in all 75 districts and skilled attendance at birth including increased access to emergency fund and transportation.

Comprehensive post abortion care services were initiated in 1995 and have been expanded to 28 district hospitals. A major accomplishment of SM in Nepal is the legalization of abortion in September 2002. The safe abortion policy and procedural guidelines have been drafted and processed for endorsement.

To improve the quality of maternal and newborn care at health institutions, a process of maternal and perinatal death reviews is being instituted in hospitals in Nepal with support from WHO.

WHO and other organizations continue to support competency-based life saving midwifery skills trainings.

stocks were supplied to countries with the greatest need. These included 12 shipments to Vietnam, 13 to Myanmar, 4 to Cambodia, 5 to China, 1 to Taiwan, 3 to Lao PDR, 2 to DPR Korea, 1 to SEARO and 14 to Thailand. The final shipments continued till the last week of July and were to China and Myanmar.

Simultaneously, the Bangkok office continued to provide support to Dr. Urbani's family, in coordinating travel and accommodation and also in providing religious comfort from local Italian Catholic priests. They worked closely with WPRO and US CDC to obtain necessary expertise, drugs, supplies and equipment for the hospital and care-givers treating Dr Urbani. The Hong Kong Health Department located and provided anti-retroviral IV. A Thai International pilot agreed to hand carry the drug. The pilot radioed in and a driver met him at the gate, and the drug was rushed to the hospital an hour later. The office also provided logistics support for the two intensive care specialists flown in from Germany and Australia during the final phase of Dr Urbani's illness. Following the sad and shocking loss of Dr Urbani, the office arranged for the repatriation of his remains to Italy.

The WHO Bangkok office kept itself informed about the best possible measures for personal protection. This included seeking advice from WHO Geneva, WHO WPRO



A man helps take on the heavy work for his pregnant wife.

ANMs and MCH workers stationed at the community level health facilities are also provided with such trainings. They are also equipped with "EOC kit boxes" to provide obstetric first aid and referral for complicated deliveries occurring at home.

To overcome access issues communities are being activated and supported to organize emergency transport schemes, and community emergency funds for obstetric emergencies. In this regard the community-based female health volunteers (48,000) and mothers groups are being activated. The FCHVs (48,000) provide referral linkages between the community and the health institutions.

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and expert virologists from Australia and the USA. Working closely with US CDC they obtained the best possible respirator masks. Local representatives of 3M worked with WHO conducting training for the Disease Control and Epidemiology teams on the proper use of the N95 respirator masks and for the nursing staff at Bamrasnaradura. The WPRO Interim Guidelines on PPE proved very useful and WHO shared these with the Health Ministry's SARS Epidemiologists and the Logistics Support Unit.

The office worked closely with the Thai NIH in establishing a laboratory SARS testing process that was used for specimens from suspected/probable cases in Thailand and other countries. Protocols for sending, receiving and reporting on samples were developed and utilized.

In retrospect, throughout the crisis, what was evident among people at different levels of the Organization, were the elements of common concern, determination to act, and dedication beyond the call of duty. WHO's leadership role and position were upheld throughout the course of the epidemic, not only globally but also throughout the SEAR Region. Today the SARS networks that were established remain viable and can be reactivated should the need arise again.

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