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ACHIEVING MDGS 4 & 5: NEPAL'S PROGRESS ON MATERNAL AND CHILD HEALTH

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KEY MESSAGES:

- Nepal has made great progress in reducing maternal and child health outcomes, achieving its targets for MDGs 4 and 5a, ahead of the 2015 deadline.
- Adopting a community-based approach to service delivery and bringing critical maternal and child health services closer to the most marginalized populations has been important to Nepal's success.
- Provision of subsidized or free care for maternal and child health services has been critical in the uptake of services, especially among poor households.
- Improvements in socioeconomic status have also contributed to maternal and child health outcomes in Nepal through better access to services and reduction in poverty.

Introduction

Nepal has achieved its targets for MDGs 4 and 5a. Maternal mortality declined from 790 to an estimated 190 deaths per 100,000 live births between 1990 and 2013 an impressive 76 percent decline. Under-five mortality showed a similarly impressive decline going from 142 to 42 deaths per 1,000 births between 1990 and 2012. This HNP note explores the actions Nepal has taken to reduce maternal and child mortality.

Context

Nepal is a landlocked, low-income country with a per capita GNI (PPP) of US$1,289 (2012), and an average annual GNI growth rate of 4.4 percent (2003-2012). Headcount poverty declined from 60 percent to 25 percent between 1995/96 and 2010/11. Income inequality also declined, with the Gini coefficient dropping from 43.8 in 2003 to 32.8 in 2010. Nepal has a population of 26.5 million, and a population growth rate of 1.35 percent per annum. Fifty-seven percent of Nepal's population is in the 15 to 59 years age group. Nepal has a very heterogeneous society, with 125 caste/ethnic groups and 123 languages. At 59.6 percent, overall literacy is low, and considerably lower among women than men (49 percent vs. 72 percent, respectively). Free primary education has contributed to a high enrollment rate (95 percent), but it drops to 47 percent at the secondary school level, and tertiary enrolment is even lower at just over 7 percent.

MATERNAL AND CHILD HEALTH POLICIES

Nepal has prioritized family planning and maternal and child health at the national level since the mid-1960s. More recent policies are the following:

National Health Policy (1991): This policy represents a turning point, as it is the first in Nepal to adopt an integrative approach to health services. It strengthened decentralization of service delivery to the district level, and encouraged community participation through promoting female community health volunteers, traditional birth attendants, and inclusion of civil society.

National Reproductive Health Strategy (1997): This strategy focused on integrated reproductive health services to all. Several more specific policies and plans on family planning, safe motherhood, and adolescents have their origins in this strategy, helping to catalyze policy into action. This includes the National Safe Motherhood Plan (2002–2017).

Legalized Abortions (2003): A key development for reproductive health rights in Nepal, the law allows women to legally terminate unwanted pregnancies under certain circumstances.

More recently, the Government has sought to establish the right of citizens to free basic health care services. The 2008 *Aama Surakshya Karyakram* program is a step in this direction.

MATERNAL AND CHILD HEALTH PROGRAMS

Family Planning: Nepal's family planning program provides comprehensive coverage and services are provided at all tiers of the health system, as well as through outreach clinics, and mobile camps known as *sibirs*. Between 1990 and 2011 fertility declined rapidly from 5.1 to 2.7 births per woman, and contraceptive prevalence increased from about 24 percent to 50 percent.

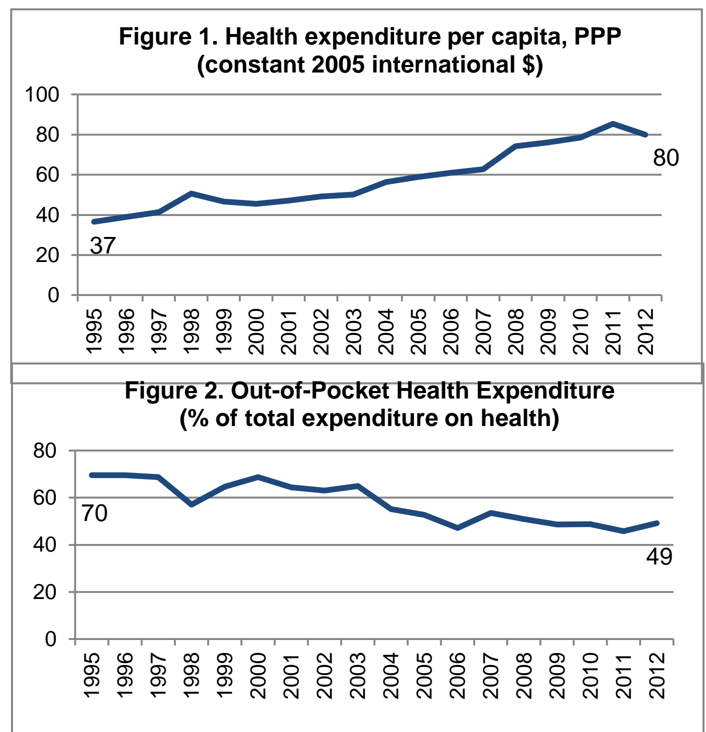
Safe Motherhood Program: Initiated in 1997, the program focuses on improving quality and utilization of services, especially emergency obstetric care. The program is implemented with support from donor partners and in collaboration with NGOs. Between 1996 and 2011, skilled attendance at birth increased from 9 percent to 36 percent and prenatal/postnatal visits went from 24 percent to 58 percent.

Community-Based Integrated Management of Childhood Illness (CB-IMCI): CB-IMCI supports the management of childhood illnesses, particularly diarrhea and acute respiratory infections. The program has helped to double the number of pneumonia cases treated since its inception covering up to 69 percent of Nepal's under-five population. The program also supports regular immunization and nutrition. Under the *National Immunization Program* vaccinations have increased, from 46 percent to 92 percent for DPT, and from 57 percent to 88 percent for measles between 1991 and 2011.

HEALTH SYSTEM

Service Delivery: The combination of a vast network of facilities and use of community health volunteers has contributed to a strong public health structure at the village level and effective dissemination of health interventions in Nepal, especially for mothers and children. Since more than half the women deliver at home, birthing centers have been established at the health post level to bring maternal healthcare closer to communities. Public health services are provided free of cost at health posts and sub-health post levels in Nepal, a right guaranteed under the 2007 Interim Constitution. As a result, utilization of the health services has increased, but it has also overburdened the health care system with, for example, supply shortages in 25 percent of facilities.

Healthcare Financing: A significant portion of Nepal's public health budget comes from donor support, coordinated via the *Nepal Health Sector Program*. Over the past decade, public expenditure on health has averaged around 11.2 percent of total government expenditure. At the same time, per capita expenditure on health (PPP) has more than doubled (figure 1). Ninety percent of private expenditure on health represents out-of-pocket spending, which is also increasing (figure 2), driven by remittance-related increases in per capita incomes.



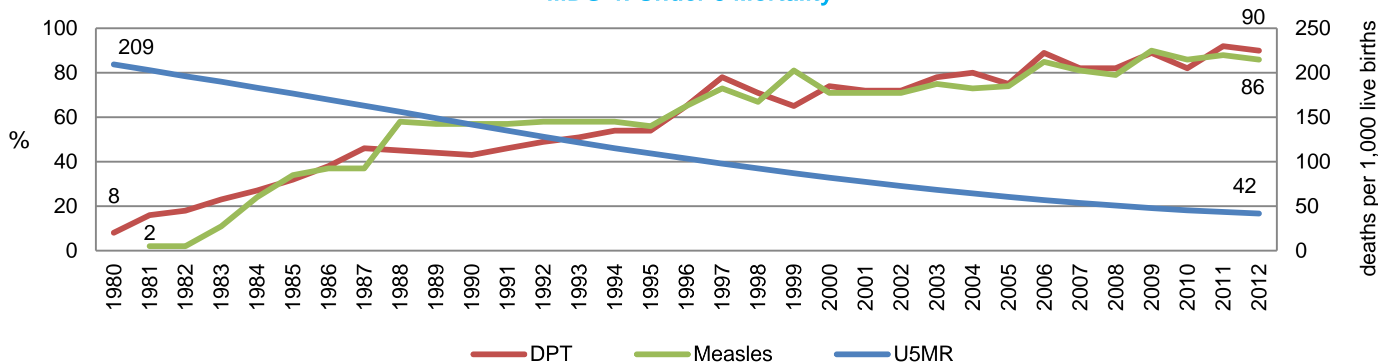
Safe Delivery Incentives Program (SDIP): Piloted in 2005, the program offered demand-side cash incentives to women for having four ante-natal visits, skilled birth attendance, and a postnatal visit. It covered the costs of transport as well, with cash transfers based on region – ranging from Nepalese Rupees (NR) 500 (approx. US$ 7.8) in the Plains (richer region) to NR 1,500 (US$ 23.4) in the Mountain districts (poorest region). The program also provided incentives to skilled birth attendants for managing home deliveries. Within a year of launch, deliveries with trained birth attendants increased from 20 percent to 30 percent.

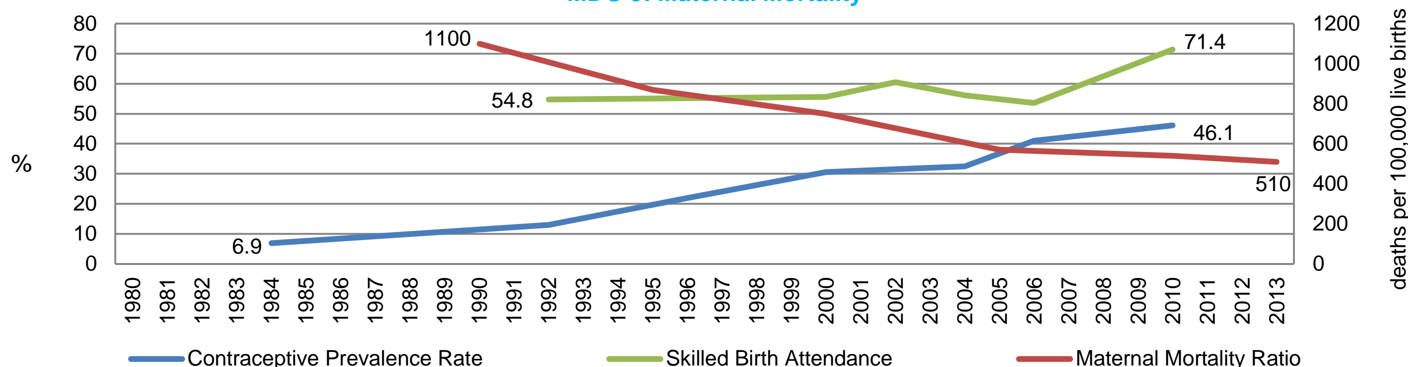
Aama Surakshya Karyakram (Aama): In 2009, the SDIP was rolled into the *Aama* program, which aims to provide

free delivery services in all public sector and partner facilities. In addition to demand side incentives, program components include free institutional delivery care and supply-side incentives to health facilities for providing free care for normal deliveries, ranging from NR 1,000 to NR 1,500. Payments increase for complicated deliveries (NR 3,000) and caesarean sections (NR 7000). A recent study of 6 districts shows that while overall institutional deliveries have increased from 17 percent to 33 percent, there are disparities in utilization at the district level.

Human Resources: Female community health volunteers (FCHVs) have played an important role in facilitating access to services for maternal and child health in Nepal since 1988. The FCHV program covers mainly rural areas

Figure 3. Nepal: Timeline of MDG 4 and 5 Interventions





Pre-1990	1991–2000	2001–2012
1965–1970: Third Five-Year Plan prompts launch of family planning, maternal, and child health projects **1965:** Immunization with DPT begins **1975–90:** First Long-Term Health Plan **1977:** Expanded Program of Immunization (EPI) **1979:** National Commission on Population established **1983:** National Population Strategy **1988:** FCHV program	**1991:** National Health Policy **1997:** National Reproductive Health Strategy **1997–2017:** Second Long-Term Health Plan **1999:** Local Self-Governance Act **1997:** National Plan of Action (NPA) for Gender Equality and Women's Empowerment **1998:** Decentralized Action for Children and Women (DACAW) **2000:** National Adolescent Health and Development Strategy	**2002–17:** National Safe Motherhood Plan **2002:** Education Regulation **2003:** Abortion is legalized **2004:** Safe Motherhood Plan revised to include neonatal health **2005:** Safe Motherhood Incentives Program **2006:** Skilled birth attendance policy **2007:** Interim Constitution **2009:** Aama Surakshya Karyakram **2009:** Community-Based Newborn Care Package

and has become pivotal for community-level service provision in Nepal. It is linked to the increase in the intake of iron supplements during pregnancy, which increased from 23 percent to 59 percent between 2001 and 2006. Maternal and Child Health Workers and Auxiliary Nurse Midwives are also important part of the strategy to provide maternal and delivery care services in communities.

Surveillance and Monitoring: Nepal has benefited from the availability of timely and reliable data on maternal and child health for the last two decades. While the HMIS is not a perfect system (for example, vital registration data are incomplete because people simply do not register births), availability of information through *Polio Surveillance* or the *Maternal Mortality and Morbidity Surveillance* has facilitated policy making and programmatic directions. Figure 3 shows a timeline of MDGs 4 and 5 interventions.

CREATING AN ENABLING ENVIRONMENT

- Reduction in poverty in the past decade due to programs such as the *Poverty Alleviation Fund* (2004), and remittances from migrant labor have contributed to higher spending on health.
- Caste and gender are major social barriers in Nepal. The 2007 Interim Constitution protects against discrimination on the basis of caste, gender or race, guaranteeing reproductive health rights and healthcare for all.
- Nepal's Education Regulation (2002) mandates free education to the poor, disabled, girls, and *Dalits* (lower caste population). The education policy also emphasizes income-generating literacy and post-literacy programs for women.

Future Challenges

- While cash incentives are alleviating some demand side barriers, what is harder to change are preferences, perceptions and mistrust of the public health sector, especially among the lower castes. The government is taking concrete steps such as planned recruitment of *Dalits* and *Janajits* (lowest castes) to provide health services in underserved areas and promote social inclusion.
- Chronic malnutrition, an underlying cause of mortality for women and children, is pervasive even among higher wealth quintiles in Nepal. While there has been some progress, with 93 percent of children 6 to 59 old months receiving the recommended doses of vitamin A, more needs to be done to ensure that both women and children receive proper nutrition.
- A large number of teenage pregnancies are unintended in Nepal, and use of modern contraceptives is low compared to other age groups, even for married teens. Moreover, there are concerns that contraceptive prevalence may be stagnating, highlighting the need for continued focus on comprehensive family planning, especially for teens.
- Income is a strong predictor of reproductive health outcomes in Nepal. For example, the total fertility rate for women in the poorest households is 4.1 compared to 1.5 births per woman in the richest households. Continued poverty reduction efforts are essential, with special attention to approaches that ensure benefits reach women and children in the poorest households.
- Further improvements in MCH require a systemic approach. Additional investment is needed for addressing shortage of human resources, improving logistics, referral systems and the quality of care. Continued political tensions however pose a challenge. Strong government leadership and accountability will be important for maintaining the current momentum and planning for the future.

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This HNP Knowledge Brief highlights the key findings from a study by the World Bank on "Maternal and Child Survival: Findings from Five Countries' Experience in Addressing Maternal and Child Health Challenges" by Rafael Cortez, Seemeen Saadat, Sadia Chowdhury, and Intissar Sarker (forthcoming)

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