NHSSP

PULSE

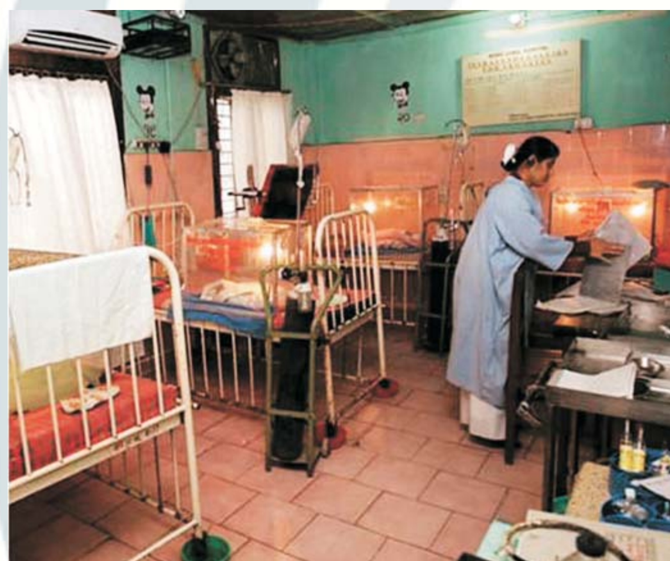
UPDATING YOU ON HEALTH DEVELOPMENTS

COMPREHENSIVE EMERGENCY OBSTETRIC AND NEONATAL CARE IN NEPAL

Are Health Facilities Ready ?

SUMMARY

- The halving of maternal mortality in 20 years (1996 to 2006), from 539 to 281 deaths per 100,000 live births, is a huge achievement, but still one women dies in childbirth in Nepal every four hours
- Continuing efforts are needed to make childbirth safer and achieve the MDG target of 134 by 2015
- Neonatal mortality has declined from 50 to 33 deaths per 1,000 live births, but the MDG target is 15
- Skilled birth attendance, backed by quality CEONC services, is critical to achieving these targets
- However the 2008/09 Maternal Mortality and Morbidity Study found that over 40% of maternal deaths occurred in hospitals, often due to inadequate or inappropriate treatment



Newborn Intensive Care Unit

Recognising the importance of Comprehensive Emergency Obstetric and Neonatal Care (CEONC) and the challenges hospitals were facing, in 2008/09, the Family Health Division/Ministry of Health and Population established a national fund for CEONC services, to support contracting of skilled providers for Caesarean Section (CS) services and purchase of specialist equipment and supplies. This complements major national programmes such as skilled birth attendant training, public information campaigns and Aama (cash incentives for mothers who deliver in a health facility and free delivery care).

Safe Delivery

KEY FINDINGS OF A STUDY ON CEONC READINESS IN 2011

- On average only 0.4% of births were delivered by CS in the 18 study districts, compared with a globally expected figure of 5%.
- This low figure is mainly due to inconsistent availability of CS services, even in hospitals receiving CEONC funding. Contributing factors are: lack of suitable applicants for key posts, lack of understanding of how the fund works and late release of funds.

- Dynamic leadership and effective management are critical. The wide variation in these sample districts is reflected in the availability (or absence) and continuity of quality services.
- Lack of equipment and infrastructure is a common problem. Even when emergency drugs are available, operating tables often need repair, supplies for newborn resuscitation are missing and water and electricity supplies unreliable.
- Record keeping and information management are inadequate, with mis-matching between information from different sources. Many staff find reporting procedures complex and difficult.
- Relationships with the local community make a big difference. Where these are good, communities raise significant funding to support the hospital. Elsewhere, health workers may feel threatened by aggressive behaviour from patients' families or political interference, which creates a climate of fear, leading to unnecessary referrals, as health staff are reluctant to risk the consequences of a patient death or serious illness.

STUDY METHODOLOGY

- Eighteen public sector CEONC sites were selected for the study, with representation from all five development regions and the three geographical zones (mountain, hill, terai). Central, regional, zonal, specialist and teaching hospitals were not included. Fourteen hospitals had received CEONC funds.
- In depth interviews were carried out with district health managers and health workers.
- Secondary data was collected from maternity and operation theatre registers, and from Health Management Information System (HMIS) and CEONC monitoring reports.
- The major focus was on CS data, used as a proxy to identify whether facilities were ready to provide complete CEONC services.

HOW THE STUDY WILL HELP

Although many of the issues highlighted are familiar, the focus of this study on CEONC readiness is important, as this is the stage at which maternal and newborn deaths are most likely to occur, when mother and baby are in dire need of high level medical and surgical treatment fast. Addressing shortcomings, based on the practical recommendations of this report, can potentially save many lives. The report confirms the fact that problems are mostly system related, and this is where efforts need to be focused.

SUMMARY RECOMMENDATIONS FROM THE REPORT

- **Staffing:** Ensure all CEONC districts have at least one obstetrician/gynaecologist or general practitioner (MGDP), one or two Advanced Skilled Birth Attendants (ASBA - graduate doctors with CS training), plus an anaesthetics assistant and operation theatre nurse.
- **Career Options:** Develop a career structure for MDGPs to make this a more attractive profession for doctors, and plan more ASBA training. Promote training for the Diploma in Gynaecology and Obstetrics.
- **CEONC Fund:** Continue this until there are sufficient sanctioned posts. Provide guidance to improve the effectiveness of service procurement to enhance accountability.
- **Fund Management:** Shift responsibility for CEONC fund management to medical superintendents.
- **Leadership and Management:** provide leadership and management orientation for hospital management committees, directors and managers.
- **Infrastructure:** Ensure facilities are CEONC ready by updating them to the required standards, protecting budgets for repair and maintenance and improving re-supply systems.
- **Monitoring Data:** Improve the quality of monitoring data, including completion of maternal and perinatal death forms, to inform decision making.

Surgery in Western Regional Hospital

NHSSP (Nepal Health Sector Support Programme) is funded and managed by DFID and provides technical assistance to the Nepal Health Sector Programme (NHSP-2). Since its inception in January 2011, NHSSP has facilitated a wide variety of activities in support of NHSP-2 objectives, covering health policy and planning; health financing; human resource management; essential health care services (EHCS); gender equality and social inclusion (GESI); procurement and infrastructure; and monitoring and evaluation. For more information visit our website www.nhssp.org.np