

# Nepal Safer Motherhood Project Evaluation Synthesis

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Executive Summary

Prepared for Nepal Safer Motherhood Project,  
Nepal

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## Executive Summary<sup>1</sup>

### 1. Introduction

#### *1.1 Magnitude of the challenge of reducing maternal mortality in Nepal*

Nepal has one of the highest maternal mortality ratios (MMR) in the world, estimated at 539 per 100,000 live births (HMGN 1996) though more recent modelled estimates by WHO/UNICEF/UNFPA (2000) put this even higher at 740 per 100,000 (range 440 – 1100). At the root of such high maternal mortality is women's low social status, played out through early marriage, poor nutrition, low female literacy, poor reproductive health (high parity, short birth intervals, high unmet demand for family planning), and social norms that leave women out of family decision-making, undervalued and disempowered. Since 1996 Nepal has experienced worsening civil conflict, a product of and now a contributor to rural poverty, which further impacts on women's lives.

Added to this scenario, is the inadequate availability of accessible, affordable and client-oriented health services that women and their families trust, want and can afford to use. The majority of women continue to prefer home births, in fact 89% of all deliveries take place in the home, of which only 13% are assisted by trained health workers, nearly 25% by traditional birth attendants, more than 50% are assisted by relatives, friends or other non-health personnel, and 10% are not assisted at all (Demographic and Health Survey, HMGN, 2001). National estimates indicate only 5% of women who need emergency care during pregnancy and delivery, receive it (referred to as 5% met need for emergency obstetric care).

The gap between where Nepal is today and the Millennium Development Goal (MDG) 2015 for improved maternal health, to which Nepal is a signatory, is huge. In just over a decade skilled attendance at birth, in home or health facilities, needs to increase from well below 20% to 90%. For deaths to be prevented, all women who suffer complications during pregnancy and delivery<sup>2</sup> need medical care, that is, there should be 100% met need for emergency obstetric care (EOC). High levels of skilled attendance and met need for EOC are expected to produce a much lower MMR. The MDG goal for maternal mortality in Nepal is in the order of 200 deaths per 100,000 live births, a reduction of two-thirds from the estimated 1990 level. Given methodological difficulties with measuring MMR itself, for project and programme purposes the proportion of births by a skilled attendant together with met need for EOC are taken as proxies for MMR.

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<sup>1</sup> The full document and other related documents can be found on web: [www.nsmg.org](http://www.nsmg.org)

<sup>2</sup> A Technical working group assembled by WHO estimated at least 15% of all pregnant women require medical care in order to avoid death or disability (WHO 1994).

## **1.2 The Nepal Safer Motherhood Project**

The Nepal Safer Motherhood Project (NSMP) is the largest and longest running project in the National Safe Motherhood Programme of His Majesty's Government of Nepal (HMGN). It is based in HMGN's Family Health Division and is funded by the UK Department for International Development (DFID) with a budget of £5.8 million over a 7-year period from 1997 to 2004. NSMP has supported safer motherhood in 10 districts, covering 15% of Nepal's population. The project aimed to contribute to maternal mortality reduction by bringing about a sustained increase in the use of quality midwifery and essential obstetric care (EOC). To achieve increased EOC utilisation NSMP worked on both the demand and supply side of the health service, enabling women's increased access to services and improving the quality of care available to them in government facilities. The project has also supported development of safer motherhood planning and policy by drawing on district experience to inform national policy and by supporting national initiatives, such as legalisation of safe abortion, which are critical for maternal mortality reduction.

NSMP was designed within a public health approach which aimed to maximize women's lives saved within given resources. When the project began the main tenets of the safe motherhood approach were family planning to reduce unwanted pregnancies, safe abortion and pregnancy complications managed. Seven years on these strategies remain valid and additionally safe motherhood now gives greater attention to focused antenatal care, skilled attendance at birth (home and facilities) and is concerned about better integration of newborn care into safe motherhood programming. Further there is greater recognition that health sector reform needs to underpin safe motherhood interventions and that safe motherhood is not only a public health issue but also needs to be addressed from a rights and social justice perspective. Over the project period NSMP's approach has been influenced by these developments in global thinking (particularly on skilled attendance and neonatal care) but the key focus of NSMP has remained the problem of managing complications in pregnancy.

## **1.3 EOC Utilisation Achievements**

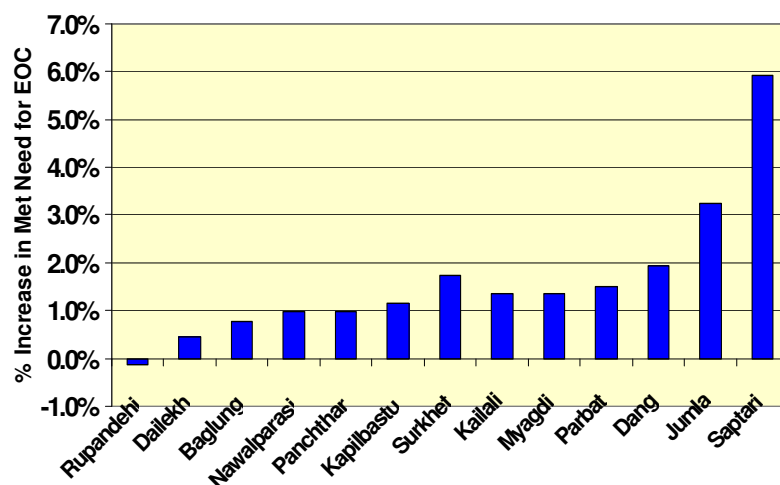
The central aim of NSMP has been to increase EOC utilisation. EOC utilisation is measured using the UN Process Indicators and monitored by the Family Health Division (FHD) of the MoH. At present 13 districts are monitored, 9 supported by NSMP and 4 by UNICEF. Over a period of 4 to 7 years, 11 of the districts have experienced an average annual increase in met need for EOC of less than 2% (Fig. 1).<sup>3</sup> This evidence shows positive change has occurred but the pace of improvement in EOC utilisation is modest. At the outset of the project the expected increase in use of EOC was not quantified as there was little experience on which to base targets. NSMP experience has shown that in the presence of all the factors described at the beginning of this document, an increase in utilisation is possible, but continuation at this rate will not achieve national and international goals for MMR reduction.

**Fig.1**

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<sup>3</sup> UNICEF supported districts are Saptari, Kapilvastu, Panchthar and Dang. The remaining districts are NSMP supported. Only Phase 1 NSMP districts, Baglung, Kailali and Surkhet have been monitored for 7 years. All other districts refer to 4 years data.

**Average Annual Increase in Met Need for EOC  
over 4 to 7 years**  
(Source FHD EOC Monitoring data)



### ***1.4 Critical Processes of Change***

Over the course of 7 years, the project has collected a wealth of experience and demonstrated much good practice for making motherhood safer in Nepal, as well as contributing to international discourse<sup>4</sup>. Synthesising the achievements and lessons of 7 years of work is an important but challenging task, but is especially difficult given the nature of improving safe motherhood. Bearing in mind the holistic approach safe motherhood demands, both in terms of the need for multi-sectoral support and also the importance of working on the demand and the supply side of health, this Executive Summary is organised around 7 critical processes of change:

- **Institutional strengthening**
- **Building partnership and commitment**
- **Local solutions**
- **Social inclusion**
- **Empowerment**
- **Working in conflict and the governance situation**
- **Costs**

The main body of the Evaluation Synthesis is structured around the Project Logical Framework and this summary cross-references to the main document where appropriate.

## **2. Experience and lessons**

<sup>4</sup> Readers are encouraged to go to the NSMP website to view the full Synthesis Evaluation and the original studies and reports on which it was based ([www.nsmpp.org](http://www.nsmpp.org)).

## 2.1. Institutional Strengthening

NSMP has heavily invested in strengthening the health service to deliver better quality care in project districts. Project support for infrastructure improvements, equipment and supplies, as well as technical training and management development have together led to significantly improved quality EOC, and contributed to improvements beyond EOC. The Quality of Care Study (2004) found the level of skills and practices of staff in NSMP supported hospitals was far better than those of equivalent providers in non-NSMP facilities (see section on Improving Service Delivery in the main report). Nevertheless, systemic constraints related to inadequate budget support<sup>5</sup>, poor human resource management and deployment<sup>6</sup>, the weak logistics and supplies management system, non-functioning referral system, and pervasive unethical practices<sup>7</sup> seriously undermine the effectiveness and sustainability of project support. Addressing these health systems issues was beyond the scope of NSMP, a district EOC project, but these findings underlie the need for future support to the National Safe Motherhood Programme to work in these areas.

NSMP's experience highlights the health system weaknesses that need to be addressed to underpin and enable maximum benefit from EOC-related service strengthening. Critical staff shortages and the frequent turnover of staff is a systemic problem that requires policy level resolution through the filling of sanctioned posts, and the introduction of a transfer policy that rewards providers prepared to work in remote districts. Health services and its human resources are evolving to meet the country's changing needs, but more effort needs to be given to ensuring that job descriptions are updated to match goals and emerging new roles, and staff performance is regularly and systematically appraised. Staff who at times have to act beyond their job description to save lives, for example, a doctor who performs an emergency caesarean section in the absence of a trained surgeon, deserve professional support and legal protection from the health service.

*"How can I ensure continuity of care and deliver quality services at my hospital if I have no say in human resource planning ? All decisions are made in the centre; I get to know only when the employee presents the transfer order !*  
*Medical Superintendent*

NSMP pioneered a participatory quality of care model that has achieved positive results. Assessments of the model have shown that district project staff, Human Resource Development Officers (HRDO), played a key role in facilitating the quality of care process and leveraging support from across hospital staff and management. The influencing role of the HRDO has been a critical factor, and in the absence of NSMP staff, there is concern that the appointed lead person within the hospital, the "Change Agent", will struggle to gain hospital wide commitment and bring stakeholders together. It is therefore proposed that the National Programme pursue a middle path, supporting hospital based "Change Agents" but supplementing his/her role with a regional team of technical assistance that can provide on-site support for promoting and sustaining quality of care, as per the HRDO.

<sup>5</sup> For example, 80% of district hospital budgets are spent on staff salaries and allowances.

<sup>6</sup> Absenteeism and dual practice are common.

<sup>7</sup> For example, doctors receiving illegal payments from pharmacies to whom they refer clients.

The referral system is a particularly weak link in the current health service and non-responsive to the referral patterns of pregnant women most of whom are self-referred, or referred by traditional practitioners. The breadth of the referral network for safe motherhood needs to be widened and incentivised, and back referral systems created. The EOC Utilisation Study (2004) found that MCHWs who accompany their clients to hospital are stopped from entering the hospital because they lack identification, leading the MCHW to “lose face” and credibility, undermining her referral role. The project has equipped and upgraded many health facilities, but this investment has not been adequately shadowed by long-term budgeted maintenance support. A lesson for the National Programme is that each facility needs to allocate resources for physical and equipment maintenance and that this allocation requires rigorous monitoring.

The increasing access component of the project focused on strengthening district institutional coordination structures to institutionalise safe motherhood, namely Reproductive Health Coordination Committees (RHCC) and Safe Motherhood Forums (SMF). NSMP has demonstrated the value of RHCCs/SMFs, encouraged their ownership of safe motherhood and mobilised local political commitment. There is an important role for RHCCs/SMFs under the National Programme, although there is a need to clarify their position within government structures, so as to promote district ownership, and to support their functioning (see the section on Increasing Access in the main report).

Despite lobbying, NSMP’s district focus on institutionalising access has not been mirrored at the national level, and this remains a priority task for the National Programme. National level ownership of the access side of safe motherhood needs to be secured and administrative responsibility assigned. This will entail strengthening the national Safe Motherhood Sub-Committee and National Reproductive Health Coordination Committee to give greater priority to access, and to perceive access and service provision as points on a continuum of safe motherhood, rather than existing in separate boxes. A single apex body to oversee access and service programming will further enable more holistic programming.

## **2.2 Building Partnership and Commitment**

The multiple factors underpinning women’s health and safe motherhood<sup>8</sup> demands a multi-faceted programme response operating at various levels of governance, through a variety of approaches and sectors, and across a wide range of actors. The complexity of enabling safer motherhood in Nepal as in other countries, calls for mobilising the commitment and resources of actors and organisations across the country. To achieve this, NSMP adopted a partnership approach at district and national level, both within its increasing access and service provision areas of work. By building district networks and supporting local partners, the project has shown that a partnership approach can successfully mobilise local political commitment and multi-sectoral support, and harness the participation of local organisations to deliver activities. For example, in most of the project districts, District Development Committees have allocated their own

*“The issue of maternal health is not an agenda of health sector alone. It would be impossible to reduce maternal mortality if health sector alone took the responsibility.”*

*Chief District Officer*

<sup>8</sup> Low status of women, socio-cultural norms and beliefs, economic, geographical, political, legal, community perceptions, nature and availability of services.

funds to safe motherhood. Line agencies and NGOs have also demonstrated willingness to integrate safe motherhood activities into their own development programmes. At the national level, the Safe Motherhood Network has proven a staunch ally and effective mobiliser of political support.

NSMP adopted a pragmatic approach to selecting district partners, placing priority emphasis on scaling up in order to meet the time-bound project objectives. The result was the selection of more mature and organisationally strong NGOs that could absorb safe motherhood technical inputs, but not those working in the remotest areas or with the most vulnerable populations. From this experience, NSMP has learned several lessons to inform the National Programme:

- Local NGOs and CBOs require organisational development support if they are to sustain safe motherhood activities and become long-term agents of change.
- Organisational development support is particularly necessary for those organisations from and working in remote areas and with vulnerable populations.
- The provision of management and organisational capacity building support to local partners is most efficiently achieved by contracting out those services to experienced and relevant service providers.
- Transparent bidding processes are fairer and more inclusive, but need to include mechanisms to protect local NGOs and CBOs working in vulnerable areas.

NSMP contracted out much of its technical safe motherhood training to national NGOs. This approach has proven successful in that quality training has been delivered without burdening the overstretched Government system, and warrants continuation under the National Programme. NSMP gave less attention to the formation of service delivery partnerships with the private sector (for-profit and non-profit), although as the Utilisation Study clearly highlights, in some districts, they have become the preferred and primary supplier of EOC. To maximise the potential contribution of the private sector to reducing maternal mortality, and to protect the health and interests of clients, the capacity of the Ministry of Health needs to be strengthened to regulate and accredit private facilities. The QOC framework pioneered through the project provides the basis for accreditation, and for raising standards of care in private practice. Given women's increasing use of private providers for EOC, there is a need to include private providers in the EOC monitoring system, and this in itself will be a potential bridge-building activity between the public and private sectors.

### ***2.3 Local Solutions***

The social and cultural diversity and stratifications of Nepalese society together with Nepal's topography underline the importance of local solutions. Local approaches to tackling locally defined challenges using local resources and capital is good development practice, and NSMP is rich in such good practices. NSMP's community based transport schemes and emergency funds are examples of how the project has worked with existing community groups to mobilise support and foster ownership. The project's strong endorsement of local knowledge and non-harmful beliefs has created space and respect for traditional practitioners to be part of the safe motherhood movement with positive benefits in reducing common delays in deciding to seek EOC. Local solutions to improving the quality of health care are equally important. Across Nepal and the region, staff from the immediate locale are more likely to remain in health facilities than those from outside the area, particularly in remote areas, and they are more acceptable to users.

NSMP has shown that local solutions create greater ownership and potential sustainability and, by their very nature, are more empowering than top-down interventions. Learning from NSMP's experience, we see that local initiatives are central to enabling access to EOC, and opportunities for joining them up, such as linking community transport schemes and emergency funds, and linking community emergency funds and hospital exemption schemes, present additional potential benefits that need to be seized (see the section on Community Based Transport and Funding Schemes in the main report). NSMP has shown that scholarships to local students is a viable means of encouraging staffing of remote facilities and is a credible policy option for the future. Efforts to strengthen Hospital Management Committees (HMCs) to be more responsive to the local environment have had mixed results. Constrained by the dissolution of local governments, the public accountability of HMCs has been undermined and local initiative stymied. Once local government is restored, the Local Self-Governance Act completed, and the rights of citizens clarified and institutionalised, there will be significant potential for hospital managers to be held more accountable by the public, and for HMCs to become a forum in which citizens can demand greater responsiveness.

During NSMP, the achievements and dynamism of local practice have informed policy and programme development. This is important as evidence generated from within Nepal has a particularly strong influence on policy. The National Programme should encourage development of learning systems that can continue to draw on in country and also the development of horizontal learning mechanisms. For example, local partners in one district share and learn from the experience of partners in other districts.

## ***2.4 Social Inclusion***

Designed in the mid-1990s, the project adopted a public health approach to maternal mortality. NSMP aimed to save the maximum number of women's lives and increase utilisation of EOC at the aggregate level, without attention to the relative rate of change among different population groups. An important consequence was that although NSMP was working in some of the poorest districts in the country<sup>9</sup>, the project did not target vulnerable groups at the local level nor ensure their inclusion in project activities. In response to Nepal's evolving national poverty reduction and development strategies, and prioritisation of equity and social inclusion, NSMP has taken a more critical analysis of who is being reached by the project and why, and has taken social inclusion into evaluation and learning activities to inform the National Programme.

The Utilisation Study found a major gap in the EOC utilisation rates of women from Janajati, and to a lesser extent Dalit, backgrounds, compared to their proportion in surveyed district populations. The Increasing Access Review provides valuable insights into the processes at play that continue to exclude vulnerable groups, processes both specific to the original design of NSMP, as well as social and cultural processes embedded in Nepalese society (see the section on the Complexity of Enabling Increased Access in the main report). Various pieces of research commissioned by the project show that reaching vulnerable populations - be they the ultra-poor, those living in remote areas, occupational castes, ethnic groups, religious minorities - will cost more, require locally contextualised approaches, and will take longer than more accessible populations.

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<sup>9</sup> Dailekh and Jumla ranked

The evidence and analysis of how NSMP's public health approach failed to protect the interests and participation of vulnerable groups underlines the need for the National Programme to take a much stronger and targeted approach to social inclusion. To ensure that the nation's political commitment to promoting social inclusion and greater social justice and equity is translated into practice, it will be essential that social inclusion is strategically mainstreamed through the National Programme.

### ***The Gap***

*In Rupendehi District, Janajati women made up 61% of the female population of reproductive age but only 28% of EOC users in 2003-4, Dalit women made up 12% of the same population, but only 8% of EOC users.*

Mainstreaming will be critical across programmatic areas (within health services, across partnerships, through increasing access pathways) through planning and monitoring processes, and at all levels of action. At a minimum this will require the National Programme to:

- include social inclusion as a measurable objective,
- increase resource allocations for remote and vulnerable groups,
- promote and improve the targeting of disadvantaged groups,
- plan for a long-term investment,
- use poverty criteria to plan coverage and phasing and
- include performance indicators that are disaggregated by socio-economic status and locality.

## **2.5 Empowerment**

The multiple barriers women face in accessing EOC and the multiple constraints service providers face in providing quality EOC highlight in both arenas a lack of voice, agency and self-confidence to make decisions and affect change. To address this situation, NSMP has taken a whole community approach, informing and mobilising all members of the community and family to increase knowledge of the danger signs and where to go in their event, to raise the importance of women's health, and promote proactive support and monitoring of women during pregnancy and childbirth. In addition, NSMP partners have worked through women's groups to raise their confidence and voice through peer support and encouragement. There are many examples across the project of empowered women speaking out for themselves, their families and peers, and of men asserting the rights of women. However, there are equally many examples of continuing oppression and hardship. Traditional values are slow to change and, in the main, women are still marginalised in family and community decision-making, and expected to obey their husband's and mothers-in-law<sup>10</sup>.

Dalit, Janajati and ultra-poor women face the multiple disadvantages of being women, being extremely poor, and belonging to socially marginalised groups. Caste and ethnic discrimination persists but is changing. Traditional taboos against close contact between higher castes and occupational castes are slowly breaking down, and there are examples of Mother and Child Health Workers (MCHWs)<sup>11</sup> attending Dalit births and cutting the cord themselves, rather than using traditional lower caste practitioners to do so. In formal health settings, the Quality of Care Study

<sup>10</sup> The Utilisation Study (2004) found that male family members made 83% of family decisions on whether to seek EOC, husbands 35% and fathers-in-law 48%.

<sup>11</sup> The majority of which come from higher caste backgrounds

(2004) found that women and their families feel uncomfortable and disempowered, unable to ask questions of providers or make demands. Despite intensive support to improve the quality of care within NSMP supported facilities, provider interaction with clients and families remains poor and uninformative.

NSMP's Increasing Access Review (2004) found that the project had enabled women to gain voice and agency in a range of settings. Based on this review, there are a number of good practices and lessons for scaling up under the National Programme:

- Continue the whole community approach,
- Encourage local solutions to tackling the social exclusion of Dalits, Janajatis and ultra-poor women,
- Use local mobilisers that belong to the local community,
- Identify and use synergies with other women's empowerment programmes,
- Inform women of their right to quality care and coach them to develop self-confidence in their interaction with service providers.

To address the prevailing attitude of 'ke game' among health providers, and support confidence building and self-empowerment, the project developed a whole site approach to quality improvement, and appreciative inquiry methodologies to personal growth. The appreciative and team-building approaches have been extremely well received by participants and have reportedly led to increased appreciation of all team members in the hospital regardless of position, from peon to doctor, and increased respect for and empowerment of nurses. Research has shown that nurses are now confident to make case management decisions, whereas previously this was left to doctors, even though nurses provide a significantly greater share of basic emergency obstetric care<sup>12</sup>. It is now also the case that in some hospitals, nurses have the authority to spend hospital funds on improving the quality of care. Despite important progress in empowering individual providers and hospital teams, the wider hospital environment and health system does not currently reinforce the positive attitudes encouraged through appreciative inquiry training, and there is a question mark over the extent to which new thinking and motivation can flourish in the absence of health sector reform<sup>13</sup>.

NSMP has shown the benefits of a whole site approach and a participatory quality of care model, both of which are ready for scaling up through the National Programme. However, the continuing challenge to empowering clients within health facilities demands fresh approaches. From NSMP experience, it seems that more attention needs to be given to working on the supply and demand side, both informing clients of their rights to quality care and creating institutional mechanisms and legal redress so that citizens can claim their rights. A high priority is strengthening existing complaints systems, which at present are poorly known of in the community, and equally poorly understood by providers. Implementation of the quality of care model needs to give even greater priority to positive provider-client interaction. Findings from the Quality of Care Study reveal weak performance in this area despite NSMP's efforts and this area deserves attention as word-of-mouth testimonials of hospital clients reportedly have a strong influence on EOC seeking behaviour. The lesson for the National Programme is that greater emphasis needs to be placed on improving

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<sup>12</sup> Quality of Care Study, ODC 2004

<sup>13</sup> Wilkinson, David, 2003

provider-client interaction within the framework of quality of care, requiring increased supervision, monitoring and incentives for good performance.

## **2.6 Conflict and Governance**

The conflict has had a major impact on development in Nepal, safe motherhood included. A study which examined the impact of the conflict on safe motherhood<sup>14</sup> calculated conflict has added an additional 10% to the normal delay women experience in seeking, reaching and receiving EOC. The reduced availability of transportation and curfews have had most impact on the process of accessing services once the decision has been made to seek care. But the conflict has also resulted in enhanced fear about travelling beyond the village, especially at night. It has also reduced the level of community level outreach by health workers and social mobilisers, stimulated urbanisation, increased unemployment, reduced district development budgets, and increased health staff absenteeism in some areas.

However the conflict has also encouraged some positive developments in Nepal, developments that have resonance within NSMP. It has increased attention to social inclusion and equity, has reinforced the value of local group structures, improved transparency and accountability, and encouraged local solutions, staffing and leadership.

One of the overall fallouts of the ongoing conflict and political instability in the country has been the stalling of decentralisation and the dissolution of local elected bodies. The result at the district level has been the creation of a political vacuum and chronic uncertainty, which undermines leadership and management authority. NSMP has had to work within this situation, but it has meant that local governance structures have lost legitimacy and accountability, opportunities for strengthening mechanisms of accountability have been shelved, and the power of local leaders to guide through sensitive reforms has been eroded.

## **2.7 Cost of EOC**

A study commissioned by NSMP on 'Coping with the burden of the Costs of Maternal Health'<sup>15</sup>, found that the costs of delivery for the household are high, and for many unaffordable. The average total cost of a vaginal delivery at home is Rs. 693, for a normal delivery in hospital Rs. 5,457 and for a caesarean section Rs. 11,070. Women are willing to pay for emergency care but are unable to do so without borrowing money or selling assets. Hospital costs are impoverishing, pushing poor people further into poverty. At present, hospital exemptions do not protect the poor, and the poorest women pay the same costs in hospital as the least poor. In fact, user fees are currently covering almost 100% of the real cost of providing hospital EOC and are inequitable.

Structural conditions exist that inhibit fairer and more affordable costs of EOC: there is strong pressure on hospitals and staff to generate income; rent-seeking practices between doctors and pharmacies exacerbate the high cost of drugs and supplies; and while central policies dictate allocations for the indigent, there is no central reimbursement of such funding. The perceived and actual cost of EOC is a major inhibitor of EOC use, and requires the priority attention of policy makers and programme managers to make it more affordable and equitable. Reform of exemption systems to make them work for the poor is critical. This will require a radical shift in the existing

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<sup>14</sup> Beun and Neupane 2003

<sup>15</sup> Borghi, Ensor, Neupane and Tiwari 2004

exemption framework to include transport costs, the costs of medicines and supplies that have to be purchased outside of the hospital, and special attention to the public dissemination of new exemption schemes. Such reforms will need to be carefully targeted so that they protect the poor without extinguishing the willingness of the non-poor to pay for services or encouraging elite-capture, and are likely to require piloting before scaling-up. Increased subsidies for the poor will demand increased financing from central Government as they are unlikely to be feasibly supported by local hospital initiatives, and further scenario resource planning is required.

### **3. Conclusion**

#### ***3.1 Pace of change***

Experience and lessons from NSMP have shown that a district EOC model can substantially improve availability and quality of care within project districts and stimulate change within communities to increase women's access to EOC services. However, these improvements have resulted in relatively modest gains in utilisation of midwifery and obstetric services by women who have life-threatening complications during pregnancy and delivery. Increase in EOC utilisation is on average 1.2% annually in NSMP supported districts.

#### ***3.2 Complexity of change***

The evaluation process has highlighted the complexity of the change process towards better maternal health. Whilst the aims of increased skilled attendance and use of EOC are highly specific, achieving this encompasses an enormous spectrum of change. This includes influencing dynamics within families and at the societal level; defining roles and strengthening relationships within the health system both at the level of individuals and institutions; facilitating the interface between health facilities and communities, health providers and clients; and creating a climate for collaborative effort for safer motherhood from other sectors.

#### ***3.3 Long-term commitment to change***

All this experience from NSMP shows that improving maternal health in Nepal requires a long-term commitment from the government, its development partners and civil society. Experience from within Asia during the mid 1960s to 1970s (Sri Lanka and Malaysia) suggests maternal mortality can be halved in a decade<sup>16</sup>. A study of successful maternal mortality reduction in other countries in more recent years (late 1980s to 1990s) indicates a similar time frame is needed<sup>17</sup>. However, in all these countries reduction in MMR has been measured from a much lower starting point than the level in Nepal today. The present evidence from Nepal suggests MMR reduction is moving at a slower pace that experienced in the 'success countries' cited in the studies. This evaluation synthesis has revealed both the gaps in progress and the opportunities to increase the pace of change. A significant reduction in MMR in Nepal will not take less than a decade, but in this period quantifiable improvement in maternal health should be evidenced if the opportunities shown today are seized.

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<sup>16</sup> Reducing maternal mortality in a context of poverty, Lefberghe and Brouwere in Studies in HSO&P 2001

<sup>17</sup> Koblinski and Campbell, World bank 2003