STRATEGY FOR SKILLED HEALTH PERSONNEL AND SKILLED BIRTH ATTENDANTS 2020-2025

Government of Nepal
Ministry of Health and Population
Department of Health Services
Family Welfare Division
Kathmandu, Nepal

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PREFACE

Nepal has made significant progress in Maternal and Newborn Health in the past two decades by reducing maternal and newborn deaths, but more efforts are needed to achieve target set by Sustainable Development Goals (SDGs). The National Safe-motherhood and Newborn Health Programme aims to reduce maternal and newborn mortality to meet SDG targets by 2030.

The Constitution of Nepal *(2015)* not only established the country as a federal system with three tiers of governments but has also established health as basic human rights. *Rights to Safe-motherhood and Reproductive Health Rights Act, 2018* has established maternal and newborn services as rights for the citizens. The *Joint Statement, 2018* published by WHO with other partners has emphasised continuum of care, respectful maternity care, human right based approach, and service provision by a team of competent skilled health personnel for the quality MNH services. Additionally, *National Safe-motherhood and Newborn Health Roadmap 2030* recommends revision of Skilled Birth Attendant (SBA) Strategy 2006 as an interim measure to ensure services provided by competent skilled health personnel.

In this context, the SBA Strategy has been revised as 'Strategy for Skilled Health Personnel (SHP) and Skilled Birth Attendants (SBAs), 2020-2025' and as outlined in this strategy, the National In-service Training Strategy for SBAs, 2006-2012 has also been revised as '*In-service Training Strategy for Skilled Health Personnel and Skilled Birth Attendants, 2020-2025*'. These strategies would play key role in contribution fulfilling the spirit of Rights to Safe-motherhood and Reproductive Health Rights Act and achieving towards SDG goals till 2025, and guiding health system as an essential strategy for providing quality services and for the transition for SBA led to SHP led maternal and newborn services in Nepal.

I am pleased to know that the Ministry of Health and Population through its Department of Health Services, Family Welfare Division (FWD) has led the revision of these important strategy 'Strategy for Skilled Health Personnel and Skilled Birth Attendants, 2020-2025' with the efforts of the Ministry and all its health sector stakeholders. Building on the achievements in reducing maternal and newborn mortality over the past decades, this strategy provides us a clear pathway and leads us towards achieving the Sustainable Development Goals of reducing maternal and newborn death. At the end, I would like to thank FWD Director and his team for their leadership and hard work in revision process.

Dr. Dipendra Raman Singh
Director General
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ACKNOWLEDGEMENT

National Safe-motherhood and Newborn Health (SMNH) Program is one of the priorities programmes of GoN/MoHP which aims to achieve SDGs targets pertaining to maternal and newborn health. Family Welfare Division has worked together with National Health Training Centre for revision of Skilled Health Personnel (SHP) and Skilled Birth Attendant (SBA) 2020-2025 strategies. These would play vital role in providing guidance in implementation of National SMNH program.

First of all, I would like to thank, Dr Yadu C. Ghimire, Director, National Health Training Centre and its formal Directors Mr Jhalak Sharma Poudel and Mr Mohammad Daud for their guidance in developing these strategies and his team members. Similarly, I would like to thank Ms Roshani Tui Tui, Director, Nursing and Social Security Division for guidance and inputs, particularly aligning with nursing and midwifery programme, along with her team.

I would like to thank the members of Skilled Birth Attendants (SBA) forum for thoroughly reviewing the draft strategies and providing valuable comments and suggestions which helped to improve this strategy. I would also like to thank WHO, SSBH, UNFPA, UNICEF, GIZ, OHW, Jhpiego, NSI and Safe-motherhood Network Federation who participated and provided inputs in various workshops and meetings and providing relevant resource materials. Similarly, I am grateful to Nepal Nursing Council, Nepal Nursing Association, Midwifery Society of Nepal, Nepal Society of Gynaecologist and Obstetricians, Perinatal Society of Nepal, Nepal Paediatric Society, and Institute of Medicine for their feedback and contributions. In addition, I would like to appreciate the contribution made by SBA trainers from various hospitals in Nepal especially Paropakar Maternity and Women's Hospital.

Most importantly, I would like to thank Dr Punya Paudel (Chief, Maternal and Newborn Health Section) and her team for providing overall leadership and hard work in the revision process.

Finally, I would like to thank Nepal Health Sector Support Programme for the technical support and UKaid financial assistance to FWD and NHTC in the revision process. I would also like to thank for tireless efforts of consultants Prof. Dr Madhu Devkota and Dr Rajendra Bhadra for preparing the revised strategies.

Dr Tara Nath Pokhrel

Director, Family Welfare Division

List of Acronyms

ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
BEONC	Basic Emergency Obstetric and Newborn Care
BHCP	Basic Health Care Package
CCPDM	Committee for Program Development and Management
CEONC	Comprehensive Emergency Obstetric Care
CEONC	Comprehensive Emergency Obstetric and Newborn Care
CHU	Community Health Unit
CME	Continued Medical Education
COVID-19	Coronavirus Disease –2019
CPD	Continued Professional Development
EPMM	Ending Preventable Maternal Mortality
FP	Family Planning
FHD	Family Health Division
FIGO	International Federation of Gynaecology and Obstetrics
GoN	Government of Nepal
HMIS	Health Management Information System
ICM	International Confederation of Midwives
JD	Job Description
MDG	Millennium Development Goals
MMMS	Maternal Mortality and Morbidity Study
MMR	Maternal Mortality Rates
MNH	Maternal and Newborn Health
MPDSR	Maternal Perinatal Death Surveillance and Review
MSS	Minimum Service Standards
NENAP	Nepal's Every Newborn Action Plan
PHCC	Primary Health Care Centre
PNC	Prenatal Care
RMC	Respectful Maternity Care
SBA	Skilled Birth Attendant
SDG	Sustainable Development Goal
SDIP	Safe Delivery Incentive Programme
SHP	Skilled Health Personnel
SMNH	Skilled Maternal and Newborn Health
SN	Staff Nurse
TAG	Technical Advisory Group
TIMS	Training Information Management System
UHC	Urban Health Clinic
UHPC	Urban Health Promotion Centre
UNFPA	United Nations Fund for Population Activities
WHO	World Health Organisation

Glossary of Key Terminologies

Term	Definition
Auxiliary Nurse Midwife (ANM)	Auxiliary Nurse Midwife who has successfully completed 18 months (Post School Leaving Certificate-SLC) Course or 29-month (Pre-SLC) course and registered in Nepal Nursing Council
Skilled Birth Attendant	ANM who has successfully completed Module 1-3 of SHP/SBA training provided by NHTC
Skilled Health Personnel	For the purpose of this strategy, a nurse with PCL Nursing or higher degree, and doctor with MBBS or higher degree that have successfully completed Module 1-4 of the SHP/SBA in-service training provided by NHTC.
Advanced SBA	Doctors (MBBS) who has successfully completed 60-day Advance Skilled Birth Attendant Course (Module 5) provided by NHTC
Maternal and Newborn Health (MNH) Team[1]	A team comprising of obstetrician, midwife, MDGP, SHP/SBA, paediatrician, anaesthetist, anaesthesia assistant that work as an integrated team to provide the range of MNH care, including all signal functions of emergency maternal and newborn care to optimize the health and well-being of women and newborns. In Nepal, anaesthesia assistant (AA) is also part of the MNH team.
Continuum of Care[2]:	The "Continuum of Care" for reproductive, maternal, newborn and child health (RMNCH) includes integrated services for mothers and children from pre-pregnancy to delivery, the postnatal period, and childhood. Health workers provide such care through home, community, and health facilities in coordination with families and communities.
Respectful Maternity Care[3]	Care that is organised and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth

[1] Defining competent maternal and newborn health professionals. Geneva: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO.

[2] https://www.who.int/pmnch/about/continuum_of_care/en/

[3] https://extranet.who.int/rhl/topics/preconception-pregnancy-childbirth-and-postpartum-care/care-during-childbirth/who-recommendation-respectful-maternity-care-during-labour-and-childbirth

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1. Introduction

1.1 Background

Maternal and newborn health is a priority for the Government of Nepal (GoN). It has taken several initiatives and developed significant policies for guiding the programmes to safeguard the health of the mother and the baby (Figure1). The Safe Motherhood Programme that commenced in 1997 under the Second Long Term Plan (1997-2017) has grown significantly under the guidance of Safe Motherhood Policy 1998 and the National Safe Motherhood and Neonatal Health Long Term Plan 2006-2017. Two key strategies were adopted to improve maternal and newborn health: ensuring that a selection of health facilities have emergency obstetric care services available round the clock, and personnel with maternity skills were available to provide safe delivery care. Aama Surakshya Programme in 2009 with transport incentive and free delivery care across the country, encouraged women to deliver at health facilities. As a result, Nepal has witnessed substantial gains in maternal and newborn survival.

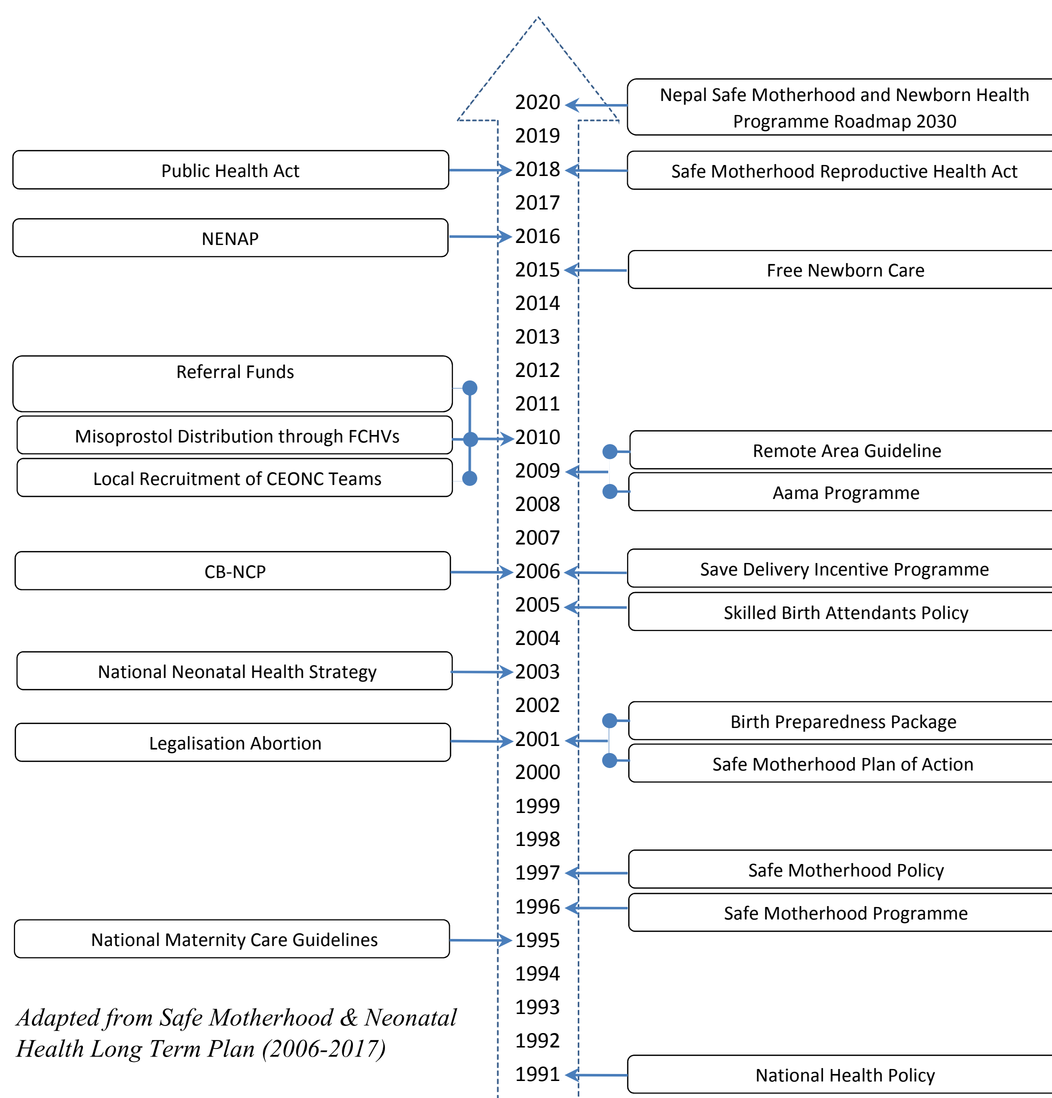


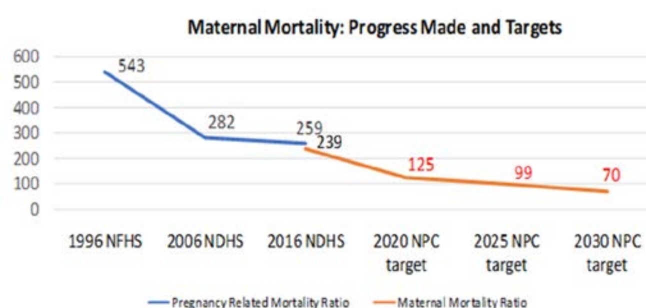
Figure 1: Selected Policies and Programmes for Safe Motherhood and Newborn Health

GoN developed the National Policy on Skilled Birth Attendants (SBAs) as a supplement to Safe Motherhood Policy in 2006. It highlights the importance of skilled attendance of every birth and embodies the government's commitment to train and deploy doctors, nurses, Auxiliary Nurse-Midwives (ANMs) and midwives with the required skills across the country. These skills were identified by the international community[4] and endorsed by the GoN. The national partners for safer motherhood supported and collaborated with the government.[5,6,7] The following strategies were outlined for making the SBAs available-

a. in the short term, the in-service doctors, nurses and ANMs received SBA training;
b. in the medium term, the pre-service training curricula of nurses, ANMs and doctors revised to incorporate the SBA skills; and
c. the long term introduced the pre-service education of professional midwives.

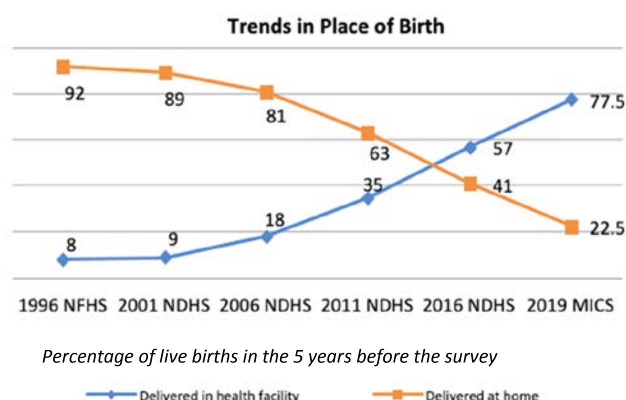
As per the records of the National Health Training Centre (NHTC), the policy has led to the training of 9489 SBAs still date. Out of the 5722 SBAs listed in the Training Information Management System (TIMS, July 2019), 74% (4226) are ANMs, 18.5%(1062) staff nurses (SN), and 7.5% (434) doctors and nurses other than a staff nurse. Midwifery education commenced in 2016.

Figure 2: Maternal Mortality Rates: Progress made and Targets



The country data indicate a steep decline in pregnancy-related mortality in Nepal from 543/100,000 live births in 1996 to 282 in 2006. The progress from 2006 onwards has been slow with the maternal mortality ratio (MMR) reaching 239 per 100,000 live births in 2016 (Figure 2). This happened despite increasing access to and use of maternal health care services. The rate for institutional delivery has increased from 9% in 2001 to 18% in 2006, 57% in 2016[8] and 77.5% in 2019[9] (Figure 3).

Figure 3: Trends in Place of Birth



Percentage of live births in the 5 years before the survey

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[4]Making Pregnancy Safer: the critical role of the skilled attendant, A joint statement by WHO, ICM and FIGO, 2004.SBA is defined as, *"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"*

[5]WHO Skilled Care at Every Birth, Report and Documentation of the Technical Discussions held in conjunction with 42nd Meeting of Consultative Committee for Programme Development and Management (CCPDM), Dhaka, Bangladesh, 5-7 July 2005

[6]''Towards skilled birth attendance in Nepal'', Rapid appraisal of the current situation and outline strategy, WHO, February 2005

[7] Taking forward the consensus from the UNFPA Regional Workshop on SBAs, Dhulikhel, FHD, Department of Health Services/UNFPA Nepal, July 26-27, 2004

[8] Ministry of Health, New ERA and ICF (2017) 'Nepal Demographic and Health Survey, 2016

[9]Monitoring the Situation of Children and Women: Multiple Indicator Cluster Survey 2019. Government of Nepal National Planning Commission Central Bureau of Statistics, United Nations Children's Fund

There is, however, an unacceptable disparity based on geography, education, caste/ethnicity, and poverty differentials. According to the Nepal Demographic and Health Survey (NDHS) 2016, home delivery without any assistance was highest (57%) in the mountain region followed by Terai (42.2%) and the hills (37.4%). Women in the mountain and hills were additionally constrained by geographic and transport-related access barriers.

Further, maternal mortality studies[10,11] as well as the hospital and community based maternal perinatal death surveillance and review (MPDSR)[12] shows an increasing number of maternal deaths occurring at the health facilities as more Nepali women access services (Fig. 4). The burden of mortality attributable to poor quality of care is increasingly a concern for Nepal, as have been shown by global realities as well.[13]

Preventing maternal death is also inextricably linked to preventing stillbirth and newborn death. Most causes of maternal and newborn deaths are preventable or treatable, and the interventions to address them well known.[14] Saving lives during this period depends upon high and equitable coverage of integrated services throughout the continuum, with linkages between the levels of care in the health system and the community[15]. A continuum of care approach that promotes care for mothers and babies from pre-pregnancy to delivery, through to the postnatal period is needed. Despite the efforts, the reduction of newborn mortality remained static at 33 deaths/1000 live births between 2006[16] and 2011[17]. It decreased to 21 in 2016[18] and further to 16 per 1000 live births in 2019 according to MICS Survey[19]. GoN is committed to reducing newborn mortality further to below 11 per 1000 live births, and stillbirth rate to below 13 (from the current rate of 18) per 1000 total births by 2035 as per Nepal's Every Newborn Action Plan (NENAP). This SHP/SBA strategy proposes to build

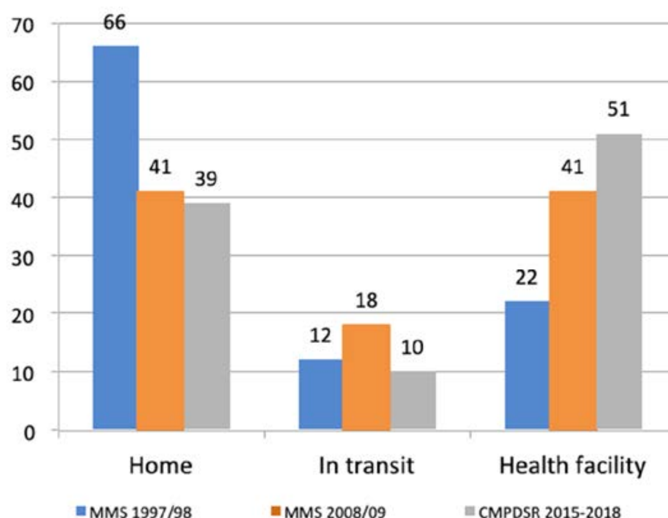

Figure 4: Deaths at home, transit or health facility

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[10]Pradhan, A., Suvedi, B., Barnett, S., Sharma, S., Puri, M., Poudel, P., &Hulton, L. (2010). Nepal Maternal Mortality and Morbidity Study 2009. Kathmandu: Family Health Division.

[11]Pathak LR, Malla DS, Pradhan A, Rajlawat R, Campbell BB, Kwast B. Maternal Mortality, and Morbidly Study (MMMS) 1998. Kathmandu: Family Health Division, Department of Health Services, Ministry of Health, His Majesty's Government of Nepal, 1998.

[12]Maternal and Perinatal Deaths Surveillance and Response: an Assessment, Family Welfare Division, Nepal Technical Assistance Group, World Health Organisation, 2019

[13] Kruk ME., et al (2018) 'High-quality health systems in the Sustainable Development Goals Era: time for a revolution' Lancet Global Health Commission

[14] World Health Organisation (2015) 'Strategies Towards Ending Preventable Maternal Mortality'

[15]Kerber KJ et al (2007) 'Continuum of Care for Maternal, Newborn and Child Health: from slogan to service delivery' Lancet vol 370 pp 1358-69

[16]Ministry of Health, New ERA, and Macro International Inc. "Nepal Demographic and Health Survey 2006." Kathmandu: Ministry of Health, New ERA, and Macro International Inc., 2007.

[17]Ministry of Health, New ERA, and ICF International I. "Nepal Demographic and Health Survey 2011." Kathmandu: Ministry of Health, New ERA, ICF International Inc., 2012.

[18]Ministry of Health, Nepal; New ERA; and ICF.2017. Nepal Demographic and Health Survey 2016. Kathmandu, Nepal: Ministry of Health, Nepal.

[19]Monitoring the Situation of Children and Women: Multiple Indicator Cluster Survey 2019. Government of Nepal National Planning CommissionCentral Bureau of Statistics, United Nations Children's Fund

upon the activities that are outlined in Nepal's Every Newborn Action Plan (2016 – 2035)[20].

An unprecedented challenge for the health system has recently emerged in the form of COVID-19 outbreak.[21] Nepal like many other countries has responded through national lockdowns to restrict the spread of the disease. This has negatively impacted not only the access to services but also the gains in mortality reduction and quality of services.[22, 23, 24]

1.2 Changed Context: Governance, Acts and Policies

Federal Structure and Responsibilities: The Constitution of 2015, declared Nepal as the Federal Democratic Republic with one Federal and seven Provincial Governments. Additionally, there are 753 Local Government Units (293 urban, 460 rural), each with significant authority. As per the Constitution, every citizen has the right to free basic health services from the state. The Basic Health Care Services Package[*](BHSP, 2018) has been formulated to operationalise the above constitutional mandate. The package includes the continuum of MNH services (ANC, delivery, PNC, newborn care), as the responsibility of the local governments, that are also responsible for local level policies and programmes related to health service management. These include the management of infrastructure, human resources, equipment, and drugs at health facilities that have less than 15 beds. Locally elected officials are now responsible for funding and programming, coordination, monitoring, and evaluation of all health services to improve the health of their constituencies.

Further, the existing district, zonal, sub-regional and regional hospitals, except the six hospitals (under Federal Government)[25], are the responsibility of the respective Provincial Governments. Their responsibility includes the provision of specialised services (caesarean sections and management of complications in mothers and the newborn babies). The Provincial level is also responsible for policy formulation, law-making, regulating quality and standards of services, management of health services, promotional programmes, coordination and monitoring and evaluation, capacity development, and emergency health service management. The Federal level is responsible for policy and law making, determining quality and standards, specialised health services, research and development, coordination and monitoring and evaluation, international relations, and capacity development. The specialised hospitals and medical colleges are the responsibility of the Federal Government.

In the above context, where basic and the specialised services fall within the purview of different levels of government, ensuring continuum of care (from basic to emergency and complication management) across the levels of health services can be challenging. A strong functional mechanism for coordination and collaboration between the three levels of governments can ensure that the services needed are readily available.

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[20]Ministry of Health (2016) 'Nepal's Every Newborn Action Plan (2016 – 2035)' Government of Nepal.

[21]Rothan HA, Byrareddy SN.The epidemiology and pathogenesis of coronavirus disease (COVID-19) outbreak.*J Autoimmun*2020; **109:** 102433.

[22]Menendez C, Gonzalez R, Donnay F, Leke RGF. Avoiding the indirect effects of COVID-19 on maternal and child health. *Lancet Glob Health* 2020; **8:** e863–64.

[23]KC A., Gurung R., Kinney V.M et al. Effect of the COVID-19 pandemic response on intrapartum care, stillbirth, and neonatal mortality outcomes in Nepal: a prospective observational study. Lancet Glob Health. 2020; (published online Aug 10.)https://doi.org/10.1016/S2214-109X(20)30345-4

[24]Jha D, Adhikari M, Gautam JS et al, Effect of COVID-19 on maternal and neonatal services. Correspondence, Thae Lancet Global Health.https://www.thelancet.com/action/showPdf?pii=S2214-109X%2820%2930482-4

[25]Koshi zonal hospital, Sagarmatha zonal hospital, Narayan sub-regional hospital, Bharatpur hospital, Bheri zonal hospital, Dang sub-regional hospital, and Dhadeldhura regional hospital.

* PHA identifies BHS, then BHS packages and PH regulations, operational guidelines for BHS delivery drafted by MOHP, in process of endorsement by the parliamentary committee.

To achieve the goal for quality health care for all, **Minimum Service Standards** (MSS), a self-assessment tool for the different levels of health facilities has been operationalised to create the enabling environment for service providers as well as service users. It focuses on holistically strengthening the health facilities through improved governance and management of the facilities, clinical as well as support services.

The **Safe Motherhood and Reproductive Health Act** (2018) respects, preserves, and commits to fulfil the rights of women to safe motherhood and reproductive health services and to ensure the safety, quality, and accessibility of services to guarantee the reproductive right of every woman. It also mandates the provincial and local governments to allocate funds for reproductive health services.

The **Public Health Act** (2018) and **Regulations** (2020), focus on integrated service provision for reproductive, child and maternal health, with emphasis on quality of care and strengthening of referral mechanisms. The regulations to implement the law are being drafted, which is expected to further streamline the coordination mechanisms and accountabilities of various levels of the government in the federal context.

National Health Policy (2019) recommends one skilled birth attendant per ward (6.20.4). The operational guidelines for the Basic Health Service Package recommends birthing centres only at health post that have a catchment population of 7,000 or above. **The Safe Motherhood and Newborn Health Roadmap 2030**, recommends that all women give birth at an existing basic emergency obstetric and newborn care (BEONC) site or a comprehensive emergency obstetric and newborn care (CEONC) site that is within 2 hours walking distance, and recommends strategic birthing centre for women who are not able to access the CEONC/BEONC easily. Further, in the sparsely populated areas of the mountain and hills, the new birthing centres are set-up strategically, based on the local contextual realities.

1.3 Changed Context: Global Directions

There are concerns regarding the lack of expected decline in maternal and newborn mortality despite high coverage of deliveries by SBAs.[26] Recently, a new definition of Skilled Health Personnel (SHP) for providing care during childbirth has been put forth by the international community; and coverage of 90 percent of births by these cadres has been recommended.[27] The definition and the competencies of the SHP are presented in Annex 1. A critical progress indicator explicitly adopted for Sustainable Development Goal (SDG) Indicator 3.1.2, also by the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)[28], and by the framework for Ending Preventable Maternal Mortality (EPMM 2015–2030), is the "proportion of births attended by the skilled health personnel", which Nepal is committed to. The Global Strategy Monitoring Report 2018 highlights that globally and regionally the progress towards the SDGs has been slow on several action areas and recommends strengthening

[26] The proportion of births attended by a skilled health worker, 2008 updates. Factsheet. Geneva: World Health Organization; 2008 (www.who.int/reproductivehealth/publications/maternal_perinatal_health/2008_skilled_ attendants/en/, accessed 13 April 2018).

[27]Defining competent maternal and newborn health professionals. Geneva: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO.

[28] Nepal Safe Motherhood and Newborn Health Programme Road Map 2030, Family Welfare Division, Ministry of Health and Population, Government of Nepal, July 2019

multi-stakeholder and multi-sectoral actions over the life-course of women, children, and adolescents[29].

The WHO SEARO Technical Advisory Group (TAG) meeting held in New Delhi in Nov 2019[30] summarised that with the annual rate of reduction seen between 2010 and 2017, Nepal was on track for reduction of its maternal mortality targets. However, four antenatal care (ANC) visits, coverage of childbirth by SBAs, institutional delivery rates, and the realities on postnatal care needed significant improvements. While the progress on the reduction of newborn mortality was appreciable, it has to be enhanced to meet the formidable SDG target of 12/1000 live births. Similarly, accelerated efforts are needed to reduce stillbirths from 18.4 per 1000 (2015) to 12 or less by 2030. The SEARO TAG meeting also recommended that Nepal should work towards the WHO Standards for the health-care workforce and increase their numbers and competencies, particularly for maternity services.

As per evidence, Nepal remains in stage III of Obstetric Transition (MMR 250-99, variable fertility and predominant direct causes of mortality). This is the 'Stage at which the tipping point occurs. Access remains an issue for much of the population, but the third delay becomes important. The significance of quality of care, with skilled personnel and appropriate management of complications and disabilities becoming important at this stage."[31]

2. Rationale

Slower decline in maternal mortality despite an increase in the percentage of institutional deliveries and skilled birth attendance has called for a review of efforts till date, and a renewed concerted effort for Nepal to achieve its SDG goal and targets. The aim is to reduce the Maternal Mortality Ratio (MMR) to 125 by 2020 and further to 70 per 100,000 live births by 2030. The proportion of births attended by skilled health personnel must be increased to 90% by 2030[32]. Newborn mortality must similarly be reduced to 17.5 by 2020 and 12 per 1,000 live births by 2030 as outlined earlier. To achieve these maternal and newborn health targets, the Ministry of Health and Population (MoHP) has reviewed the programme for Safe Motherhood and Newborn Health (SMNH), and developed a Safe Motherhood and Newborn Health Roadmap for up to 2030, to steer the direction of all activities and programme that come under the ambit of SMNH.

The above review recognises the need to improve skills, training, and deployment of SBAs, who are currently one of the main service providers of SMNH covering services for antenatal, delivery, and post-partum period.[33] Additionally, the SMNH Roadmap recommends reviewing and revising the SBA Strategy and the SBA Training Strategy as part of a transitional plan to address the identified issues regarding SBA skills and their scope of work. More emphasis on training quality, continued skills enhancement, deployment, and an enabling workplace environment are duly stressed. In this context, the Family Welfare Division (FWD) and the National Health Training Centre (NHTC) have jointly

29 WHO, UNAIDS, UNFPA, UNICEF, UN Women, The World Bank Group. Survive, Thrive, Transform. Global Strategy for Women's, Children's and Adolescents' Health: 2018 report on progress towards 2030 targets. Geneva: World Health Organization; 2018 (WHO/FWC/18.20). Licence: CC BY-NC-SA 3.0 IGO.

[30]Informal communication, report yet to be received

[31]ACHIEVING UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS - BACKGROUND PAPER FOR TAG, WHO SEARO TAG meeting Nov 2019

[32]Nepal's Sustainable Development Goals Status and Roadmap: 2016-2030 Government of Nepal, National Planning Commission, Dec 2017

[33]Report from the Review of the National Safe Motherhood And Newborn Health Programme, Nepal, Family Welfare Division, Ministry of Health and Population, Government of Nepal, February 2019.

agreed to review and revise the two existing strategies: the SBA Strategy and the SBA Training Strategy.

Further, midwifery education is initiated as per the long-term human resource strategy of the National SBA Strategy 2006. To provide quality MNH services, the draft National Nursing and Midwifery Strategy and Action Plan 2020-30, aims to produce and deploy professional midwives needed across the country. It is projected that against the total 5558 midwives needed, 753 would be produced by the year 2024-2025. This clearly shows a need for an interim strategy to ensure that Nepali women continue to receive quality maternity and newborn care till adequate numbers of midwives are produced, deployed, and enabled to provide services. This SBA/SHP Strategy is aligned with the Nursing and Midwifery Strategy and Action Plan, and the draft Human Resources for Health Strategic Roadmap 2030.

3. Nomenclature of the Cadre

There has been an impassioned national debate about the cadres that should provide MNH care at the peripheral birthing centres, given the global directions and balancing them with the national realities in order for Nepal to achieve the SDG target 3.1.2. The draft Human Resources for Health Strategic Roadmap 2030 mentions ANMs as the providers of ANC, delivery services and PNC at Health Posts (HPs), as currently there are no sanctioned positions for staff nurses at these facilities. At the Primary Health Care Centres (PHCCs), and hospitals, these services are to be provided by staff nurses. It is important therefore, to advocate for creating posts for staff nurses/midwives with higher qualifications and their gradual placement at Health Posts in the days to come.

A Ministerial-level decision was taken in August 2020 regarding the nomenclature of the cadre. It approved the in-service registered ANMs to continue to be referred as Skilled Birth Attendants (SBA) and assigned the terminology of Skilled Health Personnel (SHP) for Nurses (PCL and above) and doctors (MBBS and above) engaged in maternal and newborn care. As per the constitutional and legislative provisions, the Ministry of Health and Population (MoHP) therefore, issues this *Strategy for Skilled Health Personnel and Skilled Birth Attendants, 2020-2025* using the right conferred by Articles under Chapter 3 (Safe Motherhood and Newborn Baby) and by Article 40 of the Right to Safe Maternity and Reproductive Health Act 2074 for ensuring the availability of quality maternal and newborn health services. This strategy adopts and puts forward an innovative short course to train existing providers in respectful maternity care as a member of an SMNH team* along with midwives, obstetricians, doctors, MDGPs, and others to accelerate progress towards the SDGs. The proposed strategies are based on scientific evidence, new global directions, and most importantly, practical experiences gained from implementing the SBA Strategy 2006 that had helped accelerate the progress towards achieving the MDGs 3 and 4. In keeping with the paradigm shift globally, this updated *Strategy for Skilled Health Personnel and Skilled Birth Attendants, 2020-2025*, sees Nepal's health system shifting from the focus on management of complications to a holistic continuum of care that is based on location of the SHP/SBA in the health system and the contextual realities. (Annex III for key differences).

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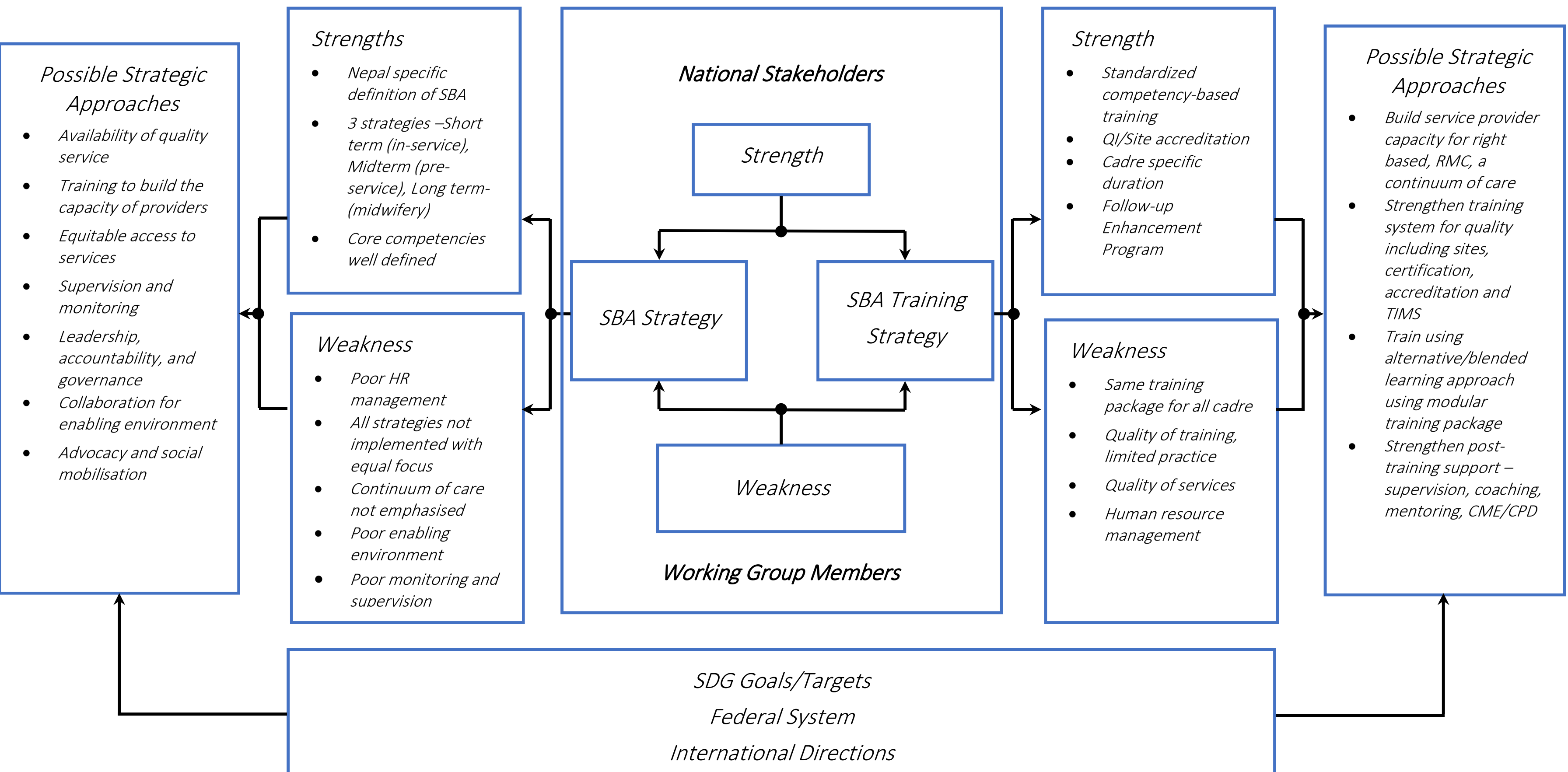
*SMNH team comprises of obstetricians, MDGP, all doctors providing MHN care including anaesthesiologist, SN, ANM, anaesthesia assistant

4. Policy Process

The policy process comprised of working closely with the 'SBA Forum', reactivated by FWD and NHTC. SBA forum meetings were the opportunities for sharing the findings of the workshops with the national stakeholders. Two workshops were held, creating the foundation for the policy revision work. The first workshop in June 2019 discussed the vision for achieving SDG targets (3.1 and 3.2) as identified in the SMNH Roadmap. Group work was done to critique the SBA Programme in achieving the national priorities and moving forwards towards the SDGs and its targets. Strengths and weaknesses were elaborated along with the recommendations for corrective measures (Detail in Annex II). The second workshop in September 2019, delved into the vision, mission, goals, objectives, and potential strategies including measures for creating an enabling environment for the MNH care workers.

POLICY PROCESS



5. In-service SHP/SBA Strategy

Vision

To ensure the fundamental rights of the mother and baby to live healthy lives, and to achieve equitable health outcomes.

Mission

All competent professionals, as part of the Maternal Newborn Health (MNH) team provide evidence-informed, human-rights-based, socio-culturally sensitive, and respectful quality of care that ensures dignity of women newborns, and their families.

Goal

To reduce maternal and newborn morbidity and mortality through quality health services, provided by SHP/SBAs working in an enabling environment.

General Objective

To ensure that the SHP/SBAs have the appropriate clinical skills, comply with the national standards and protocols, and provide evidence-based quality of care. They engage with women in a non-discriminatory and respectful manner so that the women have a positive pregnancy and childbirth experience.

Specific Objectives

1. To ensure provision for quality maternal and newborn care as per national standards and protocols at all levels of health facilities including referral services.
2. To ensure that sufficient numbers of SHP/SBAs are trained and deployed at all appropriate levels of health care and contribute towards 79 percent coverage of childbirths by the SHP/SBAs by 2025.[35]
3. To build the capacity of SHP/SBAs for better programme management and accountability.
4. To create an enabling environment for SHP/SBAs by strengthening monitoring, supervision, and support system including onsite coaching and mentoring, and continued education for quality maternal and newborn care.

6. Strategic Approaches

6.1 Ensure availability of quality MNH care at service delivery points including referral services

Enable SHP/SBAs to work together as a team to deliver a full complement of services across the continuum of care.

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[35] National Planning Commission, 2017: Nepal's Sustainable Development Goals, Baseline Report, 2017. Government of Nepal, National Planning Commission, Kathmandu, Nepal

1. Ensure readiness of MNH services using Minimum Service Standards for clinical services, management of support services, as well as good governance at the health facilities.
2. Make available appropriate human resources at all the levels of service delivery sites.
3. Make services as per standards and protocols available at the health facility.
4. Follow the Referral Guideline for Maternal and Newborn Care to facilitate a two-way referral.
5. In remote inaccessible areas, in consideration of the access and seasonal transportation issues, interventions based on the Remote Area Guidelines are considered.
6. Newborn care as envisioned by NENAP and SMNH Road Map is ensured.
7. Engage private and NGO sectors for quality MNH service provision.

6.2 Train SHP/SBAs and strengthen post-training support

Train competent and caring SHP/SBAs who work as a team to ensure quality and respectful maternity services. Continue training of advanced SBA (ASBA) and anaesthesia assistants (AA) until adequate numbers of specialists are available in the country to ensure the full range of MNH services.

1. Revise In-service SBA Training Strategy (2007) as per the SHP/SBA Strategy to ensure the competencies of SHP/SBAs.
2. Ensure the alignment of training manuals with service delivery protocols, standards, and guidelines.
3. Strengthen and expand the national health training system including the accreditation of training sites. Strengthen the certification of trainees as per cadre, in collaboration with appropriate professional bodies.
4. Use alternative approaches for in-service training using modular training package (Table 1 for details). Tailor the modules based on cadre and their workstation with special consideration to remote locations.

   This strategy proposes that:

   - All appropriate MNH team members receive basic orientation package (Module 1) covering respectful maternity care (RMC), and human rights-based continuum of care.
   - Registered ANMs are trained in obstetric first aid, physiology of childbirth, and the use of partograph (Modules 2, and 3).
   - Management of complications in childbirth (Module 4) is reserved for staff nurses (PCL and above) and doctors (MBBS).
   - Module 5 trains doctors (MBBS) working at CEONC sites on caesarean sections.

- A separate training module (Module 6) is provided to doctors (MBBS), nurses (PCL and above), and ANMs located at remote health facilities that are more than 8 hrs (i.e. 1-day travel) away from the nearest CEONC site.

5. Strengthen post-training support by building the capacity of clinical coaches and mentors; make provisions for Continued Medical Education/Continued Professional Development (CME/CPD) as appropriate for retention of skills across the continuum.

Table 1: Modular in-service training

Modules	Area of focus	The cadre of service providers	Level of health facilities
Module 1:	Basic orientation package: Respectful maternity care, a human right-based continuum of care. ANC/PNC	ANMs, nurses (PCL and above), doctors providing MHN care (all doctors working as a team- MDGP, Obstetricians, Paediatrician, Anaesthesiologist), and Anaesthesia Assistant.	Community Health Unit, Urban Health Clinic, Health Post/Basic Health Service Centre, Urban Health Promotion Centre, Primary Health Care Centre, Primary Hospital, Secondary Hospital, Tertiary Hospital
Module 2:	Obstetric First Aid (identification of risk/danger sign/complication, immediate management, and referral)	ANM, nurses (PCL and above) and doctors (MBBS) providing MNH care.	Health Post, Primary Health Care Centre/Primary Hospital, Secondary Hospital, Tertiary Hospital
Module 3:	Physiology of childbirth, use of partograph, early identification of complication and referral.	ANM, nurses (PCL and above)	Health Post with BC, PHCC/Primary Hospital (BEONC/CEONC), Sec. and Tertiary Hospital (CEONC)
Module 4:	Identification of danger signs, management of complications and referral of mother and newborn	Nurse (PCL and above), doctors (MBBS) providing MNH care	Primary Health Care Centre/Primary Hospital (BEONC/CEONC)- Secondary and Tertiary Hospital (CEONC)
Module 5	Caesarean section as Advanced SBA	Doctors (MBBS) providing MHN care	Secondary Hospital (CEONC)
Module 6	A set of skills (module 1-4) for remote areas	ANM, nurse (PCL and above) and doctors (MBBS) providing MHN care.	Health facilities in a remote area

6.3 Strengthen supervision and monitoring

Special attention is paid on clinical onsite supervision including respectful maternity care included in the guideline.

1. Update MNH supervision and monitoring guidelines to include clinical supervision of the range of MNH services. Prepare and follow the supervision protocol and calendars.
2. Strengthen clinical supervision and support by expanding on-site mentoring and coaching by trained coaches/mentors. Include practices according to protocols and checklists including respectful maternity care (RMC) across the continuum.
3. Ensure utilisation of data on monitoring and supervision for programme strengthening.

6.4 Build capacity in leadership, management, accountability, and governance

1. Understand the importance of quality, accuracy, and validity of data, including data from HMIS and other recognised sources, for programmatic decision-making.
2. Review results generated by the data, and recognise trends, identify gaps, prioritise needs of marginalised and socially excluded groups, as part of the local planning process.
3. Build capacity in accountability, transparency, and responsiveness towards service users through social audits and public hearings on service delivery issues including emergency referral experiences, in collaboration with civil society representatives and community leaders and watchdogs.
4. Ensure participation of SHP/SBAs in the appropriate management committees.

6.5 Collaborate for enabling environment

As part of a team, the SHP/SBAs need an enabling work environment to deliver the full complement of services across the continuum of care. A comprehensive approach is needed for creating an environment that takes into consideration infrastructure, safety, staffing, equipment, medicines, and supplies to ensure that all quality improvement mechanisms are in place. This would require the support of and coordination with different stakeholders, most importantly the Health Facility/Hospital Management Committees, and the Local, Provincial, and Federal governments.

Deployment and Transfer

1. Collaborate with the appropriate levels of government/bodies for stewardship role in recruitment, deployment and retention of SHP/SBAs and other staff to ensure that the right numbers and skill mix are available as appropriate.
2. Collaborate for an efficient, transparent, and predictable system for transfers to ensure that trained SHP/SBAs are transferred only to facilities that provide services relevant to their training. Ensure a predictable transfer system.
3. Coordinate with the Department of Health Services Management Division for standardised job descriptions and introduction of a functioning Performance Evaluation System.

4. Collaborate for the revision of staffing norms to align with the federal health service delivery structure as per population needs and services provided.
5. TIMS strengthened, rolled out to Provinces, and used for planning and deployment of staff to ensure that trained SHP/SBAs are appropriately deployed to health facilities where they can use their training.

Ownership and partnership with the relevant bodies

1. Ensure collaboration between the different levels of government for a complete package of basic and specialised care (Caesarean Section, management of complications in newborns) including a functioning referral system.
2. Local/Provincial governments take responsibility for planning and organising the basic and specialised MNH care for all. Local mapping is used to identify the hard-to-reach areas with remedial measures to ensure equitable access to services.
3. Coordinate for placement of staff working in remote health facilities or those with low case volume, to high caseload hospitals to refresh/retain knowledge and skills.
4. Advocate for strengthening the capacity of federal, provincial, local government to plan, deploy, and allocate budget to implement and monitor progress in MNH services.
5. Collaborate with professional and regulatory bodies for continued professional development (CPD) and creating an enabling environment.
6. Provisions for accommodation and safety along with other incentives for remote locations to improve retention.
7. Engage all levels of government and stakeholders to strengthen the Quality Assurance and Improvement System Guideline-operationalise Quality Improvement Committees to carry out self-assessment, implement remedial actions, and reporting.
8. Partner and coordinate with health development partners, private and NGO sectors, academic institutions, civil society, and professional organisations.

6.6 Institutional Arrangements

The Local, Provincial, and Federal Governments and the relevant Divisions and Centres, have an important role to play in the implementation of this SHP/SBAs Strategy. Family Welfare Division, the focal division for MNH services at the federal level, will have the lead role. The National Health Training Centre (NHTC) along with Provincial Health Training Sites will be responsible for human resource development. The roles and responsibilities of the health facilities for maternal health and newborn care services must be updated according to the SMNH Road Map 2030. Inter-sectoral and intra-sectoral linkages are strengthened to facilitate the implementation of this strategy.

Annexes

Annex I:

WHO Joint Statement on definition of skilled health personnel and their competencies[36]

The 2018 definition of skilled health personnel (competent health-care professionals) providing care during childbirth (often referred to as 'skilled birth attendants' or SBAs)

Skilled health personnel as referenced by SDG indicator 3.1.2 are competent maternal and newborn health (MNH) professionals educated, trained and regulated to national and international standards. They are competent to:

I. Provide and promote evidence-based, human-rights-based, quality, socio-culturally sensitive and dignified care to women and newborns;
II. Facilitate physiological processes during labour and delivery to ensure a clean and positive childbirth experience; and
III. Identify and manage or refer women and/or newborns with complications.

In addition, as part of an integrated team of MNH professionals (including midwives, nurses, obstetricians, paediatricians and anaesthetists), they perform all signal functions of emergency maternal and newborn care to optimize the health and well-being of women and newborns.

Within an enabling environment, midwives trained to International Confederation of Midwives (ICM) standards can provide nearly all of the essential care needed for women and newborns. * (In different countries, professionals with varying occupational titles hold these competencies.)

Competencies in Intrapartum care

* This individual possesses the following required competencies (knowledge, skills, behaviours) in the area of intrapartum care:

- can provide and promote evidence-based, human-rights-based, quality, socioculturally sensitive and dignified care to women and newborns
- can facilitate physiological processes during labour and delivery to ensure a clean and positive childbirth experience
- can identify and manage or refer women and/or newborns with complications
- can perform (as part of a team) all signal functions of emergency maternal and newborn care (basic emergency obstetric and newborn care – BEmONC; comprehensive emergency obstetric and newborn care – CEmONC) to optimize their health and well-being.

[36] Defining competent maternal and newborn health professionals. Geneva: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO.

Annex II

Major Gaps in SBA Strategy 2006, its implementation: Possible Strategic Solutions

Weakness	Recommended Actions
Implementation of SBA Policy	
SBA Policy (2006) was not supported by a strategy document. The identified short/medium and long term strategies did not receive equal attention. The short-term strategy received continuity without an alternate phasing out plan. Formidable SDG targets demand an adequate and appropriate response	While medium and long-term strategies are strengthened and rolled out, formulate an interim strategy to ensure a continuum of care until adequate numbers of midwives are produced. This interim strategy addresses the need of the country to meet the formidable SDG targets while complying with the national/ international standards to provide respectful maternity care and ensure a continuum of care.
Training	
The focus of the training was on clinical procedures and not on respectful maternity services or continuum of care. A single training package that included all the required skills was derived to train all cadres of MNH service providers. Concerns regarding the quality of the training, limited opportunity for practice during training, poor monitoring, and inadequate post-training support for trainees. Poor quality of services at the training sites limited the learning opportunities for the trainees. For example- filling of partograph was taught but was not a part of regular services at the training sites. No guidelines for capacity development of the trainers Poor ownership, logistic/budgetary support for training from the hospital management. Lack of provisions for refresher training Inadequate training sites for SBAs	Focus on the physiology of labour, monitoring of labour, early identification of risk/complications, and timely referral. Adequate focus on counselling, a continuum of care, and respectful maternity based on principles of human rights. Restructure training package and make it modular to allow training to different cadres according to the nature of their job, and the workstation they are posted in. Strengthen training sites with updated quality improvement tools and guidelines. Strengthen on-site coaching mentoring with rotation to high volume sites for skill retention. Develop guidelines for Continuous Professional Development. The trainer should be certified based on skill-based refresher training, taking advantage of e-learning. Support and commitment of hospital management and the health system to enable quality training.

Human Resource Management	
Shortage of staff	HRH Policy and Plan to be followed. Align with the Nursing and Midwifery Strategy and Implementation Plan
The trained SBAs were not deployed at appropriate facilities	Deployment of trained skilled MNH providers (SBA) at birthing centres/ maternity units/ and OMBU sites Staff placements at OPD and outreach where ANC, PNC, and FP services are provided.
The job description of each cadre was updated without considering the scope of practice that was supposed to have been developed by the professional councils. Core skills and abilities of each SBA cadre was not specified	Revise job description (JD) based on the scope of practice in collaboration with professional councils and appropriate bodies. Develop general JD for an SBA trained staff to be added with the position appointment letter. Include continuum of care service provision in SBA's JD
Supervision, Monitoring, and Evaluation	
The monitoring and supervision system for quality assurance is weak. Supervision protocol and calendar are not routinely prepared/followed. No provision for technical supervision	Use QI tools to monitor the quality of services during monitoring and supervision. Prepare supervision and monitoring plan. Close monitoring of trained staff by trainers, identify low performers and areas, followed by appropriate mentoring and coaching
Evaluation of the programme is not done by the system limiting its effectiveness, lessons learnt and the institution of corrective measures	Evaluation of the programme is done by the system. The surveys (NDHS, NLLS, NHFS, MICS) reflect outputs and outcomes.
Quality of Care	
Poor service readiness, poor communication skills and quality of care	Enhance readiness using MSS, QIP, IP Wider distribution and use of standards /guidelines service delivery protocols. Skills for effective counselling Use of QI tools during monitoring
Poor Enabling Environment	
Enabling environment not created for SBAs. Little attention to governance and accountability	Ensure safety and security. Supply of required logistics, drugs, and equipment. Legal protection of SBA for using essential drugs and life-saving procedures. Nursing staff to be included as a member of HFOMC/Hospital Management Committee Skills for effective communication and leadership for advocacy and mobilisation of resources including help for emergency transport

Annex III

Major shifts from SBA Strategy 2006

SBA Strategy	Strategy for SHP/SBA
Based on Safe-motherhood Policy, 1998	Based on Right to SM&RH Act, 2018
Aimed at achieving MDG goals	Aims at achieving SDG 2030 goals (till 2025)
Main international guidance was the Joint Statement for SBA (WHO)	Main international guidance is the Joint Statement, 2018 regarding MNH care by skilled health personnel.
Nomenclature: Skilled Birth Attendants	Nomenclature: Skilled Health Personnel and Skilled Birth Attendants.
Focused on individual SBA as providers for skilled assistance during childbirth.	Based of broader approach where cadres with different capacities and skills work as part of the MNH team
Training- focused on delivery and complication management (with 27 SBA core skills)	Focus of training on continuum of care, right based, and respectful maternity care
Training modality -group based	Training modality – alternative and modular in consideration of the cadre and their work station
Limited focus on post training support, supervision, CME and coaching/ mentoring	Adequate focus on post training support, supervision, CME and coaching mentoring
Limited focus on strengthening training system	Emphasis on strengthening training system including training quality improvement and information systems
Consideration for unitary structure	In consideration of federal structure

Annex IV:

Organisation of services and the role and responsibilities of the SHP/SBAs

1. *Referral Hospitals (existing central, zonal and regional):* In 12 selected referral hospitals onsite midwife-led birth unit (OMBU) will be established and 482 midwives (out of 753 trained, excluding 271 trainers) deployed to provide a continuum of MNH care by 2025. The existing ANMs would gradually be phased out.
2. *CEONC sites:* In the maternity wards of CEONC sites, SHP (Ob/gyn/MDGP/ASBA, midwife, nurses, anaesthetist/AA) will provide maternity care services. In the meantime, the trained registered ANMs (SBAs) would continue to provide services as part of the MNH team.
3. *BEONC sites (15 bedded Primary Hospital of Rural Municipality):* In all BEONC sites, SHPs (doctors and nurses) and other health workers with SBA training (ANM) will provide maternity care services. It is expected that gradually, the certificate midwife replace the ANM posts.
4. *Health Post:* In the selected Health Post with birthing services (strategically located), SBAs will provide MNH care. Currently, there is no sanctioned position for SNs at HP. However once they are made available, staff nurses would replace the existing ANMs.
5. *Ward level:* The National Health Policy directs the availability of one skilled service provider (community nurse/SHP/SBA) to provide a continuum of care- ANC, PNC, newborn care, and referral at every ward (6.20.4) especially in the remote hills and mountains.

Services at the different levels of care and service sites

CEONC sites

The main responsibility of CEONC sites is to provide services as per the standards and protocols. The hospital management identifies the MNH team, builds their capacity and creates the enabling environment for service provision.

The following MNH services are provided at CEONC sites:

1. Administer parenteral antibiotics
2. Administer uterotonic drugs
3. Administer parenteral anticonvulsants for pre-eclampsia and eclampsia (MgSO4)
4. Manual removal of retained placenta
5. Removal of retained product of conception (e.g MVA, dilatation and curettage)
6. Assisted vaginal delivery (vacuum extraction, forceps delivery)
7. Neonatal resuscitation (with bag and mask)
8. Caesarean section
9. Blood transfusion

Peripheral MNH service sites

The main function of these sites is to provide key MNH services depending upon the level of the health facility. At the most basic level, Health Posts function as birthing centres whereas at relatively higher-level sites such as PHCC/ Primary Hospital function as BEONC site. These sites also provide outreach services (PHC/ORC).

The following services are available at birthing centres:

- Antenatal Care
- Post-natal Care
- Assist normal physiological birth and early identification of obstetric complications and initial management (obstetric first aids):
    - **i.** administer parenteral antibiotics
    - **ii.** administer parenteral uterotonic drugs
    - iii. administer parenteral anticonvulsants (loading dose of MgSO4)
    - iv. Neonatal resuscitation (with bag and mask)
- Immediate referral of obstetric complication, after stabilisation and providing OFA.

In addition to the above, the BEONC site provides 7 signal functions:

1. Administer parenteral antibiotics
2. Administer parenteral uterotonic drugs
3. Administer parenteral anticonvulsants, for pre-eclampsia and eclampsia (MgSO4)
4. Manual removal of retained placenta
5. Removal of retained product of conception (e.g MVA, dilatation and curettage)
6. Assisted vaginal delivery (vacuum extraction)
7. Neonatal resuscitation (with bag and mask)

Disclaimer:
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