NATIONAL SAFE MOTHERHOOD PLAN

(2002-2017)

Family Health Division
Department of Health Services
His Majesty's Government of Nepal
2058 (2002)

Preface

Nepal, as a co-signatory in 1994 to the Plan of action of the International Conference on Population and Development (ICPD), has committed itself to improving Reproductive Health Status throughout the kingdom. In this regard, Reproductive Health as an approach rather than a new program seeks to strengthen the existing infrastructure and services. In order to implement this approach in a cost-effective manner the Second Long Term Plan (1997-2017) was formulated. This plan gave high priority to safe motherhood issues in particular as safe motherhood is a core component of Reproductive Health aimed at reducing Nepal's unacceptably high maternal mortality.

Since the Safe Motherhood program commenced in 1997, the program has grown significantly. A Safe Motherhood policy and clinical protocols have been developed. Similarly the role of service providers, particularly that of the maternal and child health worker has expanded and there have been considerable improvement to life saving facilities. With an increasing momentum of change there is a need to have a clear focus and direction in order to effectively manage resource and monitor change. Thus in order to focus the assistance from both government as well as non-government partners in this area and to assure effective use of resources the Safe Motherhood Plan for 15 years was developed. This 15-year plan is a long-term vision and has contributed to the HMG's 10th Five Year Plan. It was prepared using a participatory approach following a rigorous exercise of information collection, analysis and discussion. The participants of the workshop included representatives from both government as well as non-government sector.

This document outlines His Majesty's Government plan to reduce maternal mortality by providing health and development services for mothers in Nepal. The plan has set realistic targets and has a robust monitoring system to reflect the progress made. Furthermore, this document provides guidelines for policy makers, various line ministries, INGOs, NGOs and private sector organizations to identify their roles and responsibilities so that they can develop and implement activities within the framework of the plan. I will take this opportunity to call on all partners involved in SM to respect this plan and conduct programs to fulfill the objectives laid out in the plan.

It is my pleasure to thank Regional Technical Assistance (RETA) for their technical and financial support in this important area of Safe Motherhood. This document is a product of engaging and endless discussion of a group of experts and professional and I sincerely thank them for their dedication. A small group committed themselves in polishing the workshop product and bringing this document to its final shape. In this regard I would like to commend the efforts of Mr. Ajit Pradhan, Ms Susan Clapham, Dr. J. W. Harnmeijer, Dr. Geetha Rana, Dr. Indira Basnet and Ms. Sangita Khatri for their continuous involvement in bringing together this document.

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Global Safe Motherhood Agenda

Globally, awareness of the issue of maternal mortality began in 1987 at the Safe Motherhood Conference in Nairobi, which drew the attention of the world and developed countries in particular to this issue and the commitment to strive for reducing the mortality and morbidity related to pregnancy and childbirth was obtained. This commitment was reinforced in the ICPD conference held in Cairo in 1994 where in addition to the call to reduce maternal mortality and morbidity by at least 50 percent by the turn of the century, Safe Motherhood (SM) was recognized as one of the key components of reproductive health. Attention was also drawn to creating an enabling environment, enhancing gender equality equity and empowerment of women. It also gave priority in promoting reproductive health, including family planning and sexual health and reproductive rights. ICPD also emphasized the need for strengthening partnerships and mobilizing and monitoring resources, which made a significant contribution to these deaths. Nepal as a cosignatory of the ICPD conference has endorsed the Plan of Action of the ICPD. Moreover, the 1995 UN Fourth World Conference on Women in Beijing have clearly advocated an integrated approach, including health services, family planning and women's empowerment, as the immediate and most effective means to deal with health and population problems.

The Development of Nepal's SM Program

Safe motherhood has been an issue of growing importance in Nepal over the past decade. Following the conference in Nairobi, HMG/N formulated the National Health Policy in 1991, which identified safe motherhood as a priority program and institutionalized SM as a primary health care. Similarly the establishment of Safe Motherhood Task Force and the development of the National Safe Motherhood Plan of Action (1994-97) demonstrated steps towards improving maternal health status in Nepal. In 1998, HMG/MOH published the Reproductive Health Strategy, which includes safe motherhood in the integrated RH care package. This was followed by a SM Policy document that re-iterated the issues already contained in the Plan of Action 1994-97 and also gives very high priority to improving the maternal and neonatal health status of the nation. The Nepal Maternal Mortality and Morbidity Study done in 1998 is a landmark study, which highlighted the magnitude of the problem of the causes of maternal mortality in the country and galvanized the attention and resources for access to quality maternal health services. Initially 10 districts were selected as SM districts and in the first phase the program was launched in three districts. After three years the program was evaluated and an EOC model was developed and is currently being used in 13 districts

Rationale for the 15-year Plan

The past strategies of carrying out the Family Planning / Maternal and Child Health in an integrated manner, promoting attendance of birth through the TBA and promoting ANC visits were not adequate in addressing the issues of reducing maternal deaths. This is because global experience shows that all pregnancies are at risk and maternal deaths are difficult to predict. The high risk approach i.e. pregnancies that are too soon, to many, to early and too late also do not affect the maternal mortality. Experience also showed that avoidance of the three delays was imperative to achieve the goal of reduction of maternal mortality. These three delays included, delay in seeking care, delay in reaching care and delay in receiving care.

While an overwhelming multitude of constraints was evident, additional research was sought after to better understand the causes of maternal mortality. The Family Health Division (FHD) of the Department of Health Services (DoHS) therefore initiated the Maternal Mortality and Morbidity Study (MMMS) in 1996. This study gave a better understanding of the causes of maternal deaths to be 71 % by direct causes (post partum haemorrhage, obstructed labour, eclampsia, puerperal sepsis and abortion) and 29% by indirect causes and fortuitous. With 90% of the deliveries occurring at home, most of the deaths occur in the community (79%) and only 21% in the health institution. Similarly since antenatal coverage is low and since most deliveries occur outside a health institution and only 10 % of the deliveries are attended by a trained personnel (most being attended by friends and relatives) most deaths take place during the post partum period (62%). Similarly, the Needs Assessment done in 2000 (UNICEF) showed an overwhelming unmet need for basic essential obstetric care services.

In the context of the situation highlighted above the Ministry of Health's current strategy is to increase access to services at hospitals and primary health care centers through establishment of basic and comprehensive essential obstetric care and skilled attendance through trained Maternal and Child Health Workers (MCHW) at the community level. In order to overcome the second delay in reaching care the government is advocating for community mobilization for transport arrangement and is also trying to empower community, families and women both economically and socially to access care. IEC is an important aspect of the Safe Motherhood program to recognize the danger signs and facilitate to take appropriate decision to seek care on time when problem arises. Ensuring quality of basic and comprehensive essential obstetric care services avoids the third delay. Similarly women's empowerment, advocacy etc. through intra sectoral collaboration and coordination is also an important aspect of the government's strategy to improve the health status of women in Nepal. Based on these background, a new long term Plan of Action is in order

Process of Developing the Plan

Reducing maternal mortality is a complex issue. However, a vision is needed in terms of where Nepal needs to reach in the near future. Therefore realizing this; an initiative was started with a group of people with expertise and involvement in SM field to develop a SM plan for the period 2002- 2017. This plan is mainly based on the above-mentioned facts, however it is a more comprehensive document since it draws from the Second Long Term Health Plan as well. This plan gives a long-term vision of where Nepal wants to be in the next 15 years. The plan also tries to draw a balance between the supply and demand of services. For example on the demand side, the social and individual factors influence pregnancy status and the demand for services. Use of appropriate services that are supplied will result in reduced maternal and perinatal mortality and morbidity and improve health for the woman and her new born. In the case of the newborn, services are not the only alternative; improved health behavior may also result in decreased perinatal mortality and improved newborn health. In the context of scarce resources, enduring consumption also ensures optimal use of resources. The plan has also identified other key strategies to achieve the goal, which not only includes service but also training, IEC, equipment and physical facilities.

Preparations for the workshop began with the subcommittee meeting several times and a participatory planning workshop was organized by the FHD during December 5-8, 2000 to review and come up with a plan for safe motherhood. During the workshop the participants

reviewed the current strategies discussed achievements, problems and drawbacks and lessons for the future, which were the key elements for consideration while formulating the various levels of objectives and indicators. Thereafter meetings were held with smaller groups during to review the workshop outcomes and finalize the implementation plan for 15 years (July 2002-July 2017). The time frame was decided so as to make the implementation plan correspond with the five-year plans of HMG and the Long Term Health Plan of the Ministry of Health.

Plan Format

The Log Frame Matrix has been used to lay out the various level outputs and activities. The matrix consists of four columns. The first column shows the hierarchy of objectives, the second column of the matrix identifies the indicators in the base line and sets time bound targets. It also identifies how the progress is to be measured through means of verification in the third column. More importantly it outlines the assumptions and the risks, which help program implementers to identify the constraints beforehand. However the plan is not without its limitations. The SM plan at the moment does not provide the cost but the costing will be provided in the near future. The neonatal component has not been addressed although reducing neo natal mortality has been mentioned in the goal. This will be addressed as a separate document.

Planning Matrix (July 2002-July 2017)

Overall Mission Statement:

To facilitate creation of an enabling environment where a woman's right to safe pregnancy, delivery and post-partum care is achieved.

Hierarchy of Objectives	Objectively Verifiable Indicators	Means of Verification	Assumptions
Overall Goal: Maternal and neonatal health status improved*	• Reduction in MMR • Reduction in neo-natal mortality	DHS	
• **Purpose:** • Sustained increase in utilization of quality maternal health services	• CPR (for all women) increases from 39.1 in 2001to 46% in 2006, 56% in 2011 & 65% in 2016[1], 67% in 2017 • Increase in percentage of couples seeking ANC (one visit) from 49 % in 2001 (Annual Report) to 80% in 2017 2006-60% 2011-70% 2017-80% • Increase in % of deliveries by skilled attendants from 12.7% in 2001 (NHDS) to 40% by 2017 2006 – 18% (10%Home, 8% Institutional) 2011 – 23% 2017 – 40% • Increase in percentage of couples seeking ANC (four visits) from 14.3 % in 2001 (Annual Report) to 40 % in 2017 • Increase in percentage of women completing PNC (one visit) visit from 13 % in 2001 (Annual Report) to 40% in 2017 2006 -22% 2011- 31% 2017- 40% • Increase in percentage of deliveries at health facilities from 9% in 2001 (NDHS) to 22% in 2017.	• FHD Data - *HMIS;* • HMIS, Demographic and Health Survey-DHS • HMIS; DHS • FHD data/HMIS, DHS • FHD data/HMIS, DHS • Facility data; FHD Database • Facility data; FHD Database	• Assuming private hospitals and delivery

* The neonatal component will be included in a separate document

[1] Projections for Major Health Program Part II MOPE

	2006 – 12% 2011 – 15% 2017 – 22% • Increase of met needs for EOC (BEOC+CEOC) in SM designated districts from 5% in 2001 to 10% in 2006. The percentage will be reevaluated in 2006. • Increase in met need for C/S by 2% a year in SM designated CEOC districts. The percentage will be reevaluated in 2006.		institutes increase

Outputs: 1. Increased access of all relevant maternal health information and services ensured	1.1 Knowledge about danger signs in the communities among married men 15-59 increased by 10 % each five years in SM designated districts and districts with BEOC/CEOC facilities. 1.2 Household able to identify BEOC/CEOC facilities and skilled attendants by 10 % each five years until 2017 in SM designated districts. 1.3 Clients with direct obstetrical complications visiting Maternal Health facilities increased from 12 % in 1998* to 50 % in 2017 in SM designated districts. 1.4 VDCs having a functioning scheme for emergency transport and Emergency Fund increased to 50 % by 2017 in SM designated districts.	Adhoc Survey Adhoc Survey Hospital records in the districts with BEOC/CEOC facilities Administrative Records/ Community records	• Assuming the baseline on the awareness is conducted by the program implementing organisation • The Local Self Governance Act is effectively implemented • The Muluki Ain 2020 amendment bill is passed by parliament (with abortion bill) • There is effective inter-sectoral collaboration for raising social status of women • Political situation/interference does not deteriorate further • Positive behavior change can be achieved • SM continues to be a high priority in an emerging sector-wide frame • The prevalence level of HIV/AIDS does not reach significant levels to impact on maternal mortality • Adequate and appropriate human resources are available, retained and

* Maternal Mortality and Morbidity Study, 1998

			equitably distributed • The tally sheet must be put in place and the hospital staff must be trained • Private Sector's services should be included
2. Increased equity and availability of quality maternal health services ensured	2.1 Functioning CEOC sites in all 63 districts by 2017 • 33 districts – 2006 • 48 districts – 2011 • 63 districts - 2017 2.2 Functioning BEOC facilities in all 137 PHCs 2.3 Percentage increase in skilled MCHW, trained in EOC firstaid to 1 per VDC 2.4 Functioning HP with skilled attendants is increased to 90 % by 2017 2.5 Functioning SHP with skilled attendants is increased to 90 % by 2017 2.6 Locally generated resources allocated for SM at different levels of health facilities increased to 20 % each five years 2.7 MCHWs providing obstetric first aid and referral increased to 100% by 2017 and maintained	Administrative records, Regular district hospital monitoring Administrative records, regular monitoring Administrative records, regular supervision, periodic reporting of staff in place Administrative records, regular supervision, periodic reporting of staff in place Institutional reporting HMIS	Assuming expansion will be phased according to priority and plan of 10 CEOC sites and 50 BEOC sites for the 10th Five Year Plan. Political commitment is strong, Presence of skilled attendants means the facility is functioning Assessing health committees are functioning. Policy on revenue generation must be in place Allocation of at least 10% of generated resources in SM is needed

3. legal & social status of women increased	**For DHS/MoH:** 3.1 Legalization of abortion	Passage of law by Parliament and approved by HM the King	
	3.2 Decrease in number of patients admitted at hospitals with abortion related complications viz. septic abortion	Hospital data	Provided 3.1 holds
	3.3 Increase in number of doctors/nurses performing MR in all BEOC and CEOC sites		
	3.4 Protocols developed and followed in health facilities for battered women and rape victims	Protocols developed and printed	
	3.5 DHO together with NGOs and WDD establishes support services for battered women and abused children at the district level.	Support services established by DHO	Assuming there is a policy that directs the DHO to provide such services free
	3.6 Establishment/Strengthening of Health Support Committees with female representation (33%-50%) in all districts	Health support committees with female representation established	
	3.7 Advocacy for the amendment of law: personal incident birth and death registration by a single woman parent	Amendment of law	Assuming the 11th amendment is passed Assuming the 11th amendment is passed and legal age at marriage for girls is increased

	For MOE/DOE: 3.8 Percentage increase in girls enrolled in primary level education from 111.5% in 1999 to 110 in 2016• 3.9 Percentage increase in girls enrolled in lower secondary level education from 47.2% in 1999 to 105% in 2016 3.10 Percentage increase in girls enrolled in secondary level education fro 30.7% in 1999 to 58% in 2016 3.11 Percentage increase in total enrolment (male and female) in higher secondary level from 9% in 1996 to 17.46% in 2016 **For NGOs/CBOs:** 3.12 Increase in number of marriages registered by 10% each year 3.13 Increase in number of birth registered by 10% each year 3.14 Decline in girls marrying at early ages (under 20) from 43%currently married to 25% Currently married by 2017 3.15 Increase in women aware of safe abortion	MOE data, Adhoc survey MOE data, Adhoc survey MOE data, Adhoc survey MOE data, Adhoc survey Data of district registration office Data of district registration office DHS, MOPE data	

• 1999 Estimates: School Level Educational Statistics of Nepal 1999, DoE
2016 Estimates: Population Projections for Nepal 1996-2016 MOPE

National SM Implementation Plan (July 2002-July 2017)

Output: Access to Services

Activities/Sub-Activities	Time Frame	Responsibility	Indictor
1 Make existing PHC outreach clinics functional			
2 Develop and Implement National SM IEC Strategy 2.1 Ensure completion of IEC strategy on SM (to be presented to SM Subcommittee)	Ongoing	NHEICC	IEC Strategy Completed
3. Community Involvement 3.1 Advocate and lobby at all levels (political commitment by involving social organizations, political rallies, mass meetings, DDC/VDC meetings, youth clubs and local clubs)	On -going	FHD, Professional bodies, SM Network, local NGOs	Increase in budgetary allocations for SM at all levels
4. Strengthen coordination forum at district level to implement SM programs - Develop/distribute package outlining the possible inputs they can contribute - Advocate for orientation and capacity building - Review/integration of health and local government planning processes - Promote inter-sectoral collaboration for effective district safe motherhood programs (networking, sharing	On-going	SM Network, FHD Projects, PFAD, DHOs, MLD/DDCs, RHSC, RHCC, District RHCC DHO, SM Network PFAD	Districts have SM Plans Number of VDCs initiated by DDCs to have Emergency Funds for SM

resources) - Provide orientation at the local level to plan and implement SM programs - Provide orientation on role clarification of DHO and PHO in the light of the LSGS (Local Self-Governance Act)			
5. Provide orientation about their role in SM to health workers, community based volunteers, traditional healers and alternative practitioners	On-going	FHD, NHTC, DHO, SM Network (SMN)	Number of orientation conducted in---- number of districts
6. Promote and adopt innovative approaches for recognition of FCHVs by the community	On-going	DDC, VDC, DHO, FCHV Unit, SMN	Number of VDCs having programs to support FCHVs
7. Support Red Cross chapters to promote blood donations at the district level	On-going	Red Cross, DHO, DDC	Number of blood donation programs conducted Donors' groups formed at DDC and VDC level
8. Enable communities to recognize women's need for EOC and refer appropriately	On-going	SMN, NGOs, CBOS, DHO, DPHO	Number of community referrals (MOV-surveys, records, use of HBMRC- Home based Maternal Health Record Card)
10. Facilitate an enabling environment for breast feeding in a rural environment and incorporate rights perspective in breast feeding women specially regarding transmission on HIV/AIDS to babies from mothers		CHD	Incorporation in policy issues and activities of Child Health Division

Output: Equity and availability of quality maternal health services

Activities/Sub-Activities	Time Frame	Responsibility	Indicator
***1*. Strategy for Skilled Attendance in the Community** Clarify the level of competence that MCHWs shall attain to be defined as SA (Skilled Attendants)	By July 2002	FHD, NHTC	Definition (in stages) is available
2 Implement strategy to support active TTBAs/FCHVs in their partnership with MCHWs - Design strategy - Implement the strategy (in districts where MCHWs have received refresher training and equipment and supplies are available)	By July 2002 On-going	HMIDD, FHD and Ministry of Local Development (MLD)	Functioning Mothers' Groups and SHP Support Committees
3 Implement strategy for phased based, competency based training for MCHW (initially in-service, then pre-service) - Work out realistic requirements - Upgrade training centers (TOT, equipment, supplies) - Develop coordination between PHO, hospital and RTC for management issues - Carry out follow-up and monitoring Evaluate training programs	By July 2007	FHD, NHTC (with support from MLD for planning, RTC and DPHO)	Number of trainees skilled in number of competencies Numbers trained Number of centres upgraded Roles and responsibilities of PHO, hospitals, RTC clearly defined and applied for smooth functioning (planning, management and monitoring) Follow-up/monitoring system being used Evaluation completed
4 Review MCHW/ANM/Staff Nurse remuneration policy for deliveries (including home deliveries) - Develop draft policy - Advocate for policy decision - Develop mechanisms on who will pay	By July 2002	FHD, PFAD (support from MLD and Health Support Committees)	Policy drafted and presented to MoH by July 2002

Activities/Sub-Activities	Time Frame	Responsibility	Indicator
5 Implement strategy for the provision of essential drugs and supplies - Review existing essential drugs list for SHP/HP/PHC/District Hospitals and ensure that SMP drugs and equipment are included - Complete supply of RH kits (after review of contents) and also facilitate availability of these kits through private centres - Develop mechanism for replenishment of RH kits (e.g. use money raised from deliveries for SM drugs and supplies) - Ensure proper use of RH kits 5.1 Explore possibilities of integrating SM drugs into CDP (Community Drug Program)	By July 2001 Relate to training of MCHWs Starting July 2001 On-going By 2007	FHD, LMD FHD, NHTC, LMD (with support from EDPs) DHO, Local Health Committees FHD, DHO ----	Trained MCHWs have adequate drugs and supplies
6. EOC Strategy 6.1 Carry out needs assessment for mapping exercise, time-travel criteria (initially SM districts) 6.2 Implement planning process - phased approach, determine increase in BEOC and CEOC over 5 years period; 6:1 BEOC/CEOC ratio ***(Note: Discuss on number of districts with decision makers; Priority will be BEOC and then CEOC)*** - Establish BEOC in district hospitals where it does not exist and in PHCs with residential facilities - Strengthen CEOC on a 24-hour basis in facilities already providing CEOC - Establish CEOC in hospitals upgraded as per HRH Plan (joint	On-going	FHD	

planning with HRH)			
7. Implement a strategy for collaboration with non-governmental sector in order to enhance service delivery	-----	FHD, HIMDD	
8. Monitor the EOC services			
9. Develop strategy to ensure that PAC (post-abortion care) services are coordinated with and integrated into programs			
10. Special programs for selected districts	By July 2001	FHD with support from EDPs in these districts	Number of districts having special programs for Safe Motherhood
11. Develop and implement criteria for implementation of special programs in selected districts - Develop and use criteria for selecting districts and program packages - Train skilled attendants (priority to midwives/ANM/MCHW) - Provide support for transport - Develop BEOC services	} } By July 2007 }		
12. Human Resource strategy 12.1 Develop National SM Strategy Identification of levels of care/skills (BEOC, CEOC, Obstetric First Aid and IPC/C skills - Priority identification for levels of providers to be trained in SM (MCHW, ANM, SN, MO) - Identification of levels of training (Preservice and Inservice - Identification of training support b) Develop supervision and follow-up system c) Update SM knowledge and skill of health cadres incorporating national and international changes d) Establish linkage with existing SM training organizations and professional bodies	On-going June 2001	HIMDD NHTC, FHD and MNH Program/Nepal	Number of skilled personnel trained and retained National SM Training Strategy developed, approved, published

e) Advocacy and lobby for commitment to the SM services after the training - Clinical Training Site Development (selection criteria and possible institutions/facilities available) 12.2 Monitoring impact of training on service delivery			
13. Identify/establish/support training centres (clinical) for ANM, nurses, midwives, MDGP - Review the existing ANM recruitment policy - Work out realistic requirements - Upgrade training centres (TOT, equipment, supplies) - Develop coordination between PHO, hospital and RTC for management issues - Establish and implement quality control mechanism for pre-service training of ANMs - Carry out follow-up and monitoring			
14. Implement strategy for professional nurse midwife - Identify requirements (placement in District Hospitals and PHCs with BEOC but without doctors) - Promote accreditation of the midwifery course - Expand/upgrade training centers - Evaluate present midwifery course	On-going On-going	HIMDD, Nursing Council HIMDD	

15. Implement strategy for anesthetic assistants (AA) - (Sub-activities similar to the above)		FHD, HIMDD	
16. Advocate for and implement a system whereby the EOC competent staff (midwife, doctor) are retained ***(Note: Staff trained for EOC should be transferred only to facilities providing similar services, and only in consultation with FHD)***			
17. Quality of Care (QOC) Strategy 17.1 Establish a functioning national QOC Unit - Define QOC in SM/adopt appropriate models - Advocate for QOC Units at national/regional levels - Facilitate to have the QOC model adopted and implemented as per districts' needs by hospitals and PHCs - Conduct QOC training - Develop and implement strategy for monitoring QOC at the district level	By July 2001	FHD, HIMDD (Quality Assurance Unit)	Guidelines developed Number of districts following QOC Reduction in death due to maternal complications after 24 hours of arrival at the health facility
18. **Monitoring and Evaluation (M&E) Strategy for SM**			
19. Review and revise existing HMIS to respond to the changes in SM program (add indicators in APR of DHS	By July 2002	FHD, PFAD (with support from EDPS)	Indicators identified and tools revised
20. Strengthen supervisory system for SM *(Technical aspects include QOC, midwifery, BEOC and CEOC; Management aspects include drugs and supplies, reporting, HRD, training etc.)* - Develop and use checklists for technical supervision - Develop capacity at different levels	By July 2003 }	FHD, PFAD (for all the activities proposed under 5.2)	Checklists and appropriate tools developed and implemented in Project supported districts

for effective supervision - Develop and implement remuneration system for effective supervision - Involve Support Committees and Hospital/Health Facility Teams for monitoring/supervision - Coordinate with PFAD for integrating SM aspects into integrated supervision and also for effective implementation of the supervision - Carry out periodic evaluation	} } } }On-going } } } } } X(03) X(05) X(07)	 DHS, Independent Evaluator, Professional Bodies	
21. **Research Strategy** 21.1 Prioritize research needs in SM - Carry out the prioritized research Establish a resource/documentation center for SM/RH	By July 2007	SM Subcommittee, Research Subcommittee. FHD (support of EDPs), RHRSC (Research Subcommittee)	Number of research conducted with prior approval of RH Subcommittee and used to improve SM programs HMG designates staff for resource centre

Output: Legal and Social Status of Women

Activities/Sub-Activities	Time Frame	Responsibility	Indicator
1. Carry out advocacy to enforce favorable current laws and to get new laws approved - Form core group to (comprising NGOs, MoH, MWSW etc.) to reach a consensus on prioritizing various bills on women issues - Advocate and lobby for passage of various bills - Identify and select districts where the problems are severe (e.g. early marriage in Tarai districts) - Lobby to increase the age of "gauna" (minimum 18) - Provide mass orientation through formal and non-formal education channels - Provide support through ward representatives and government machinery against child marriage - Lobby to increase in quota for women in politics Strengthen compulsory vital registration (advocacy, capacity building, logistics and facilities)	Consensus within two years Lobbying on-going	FHD, SM Network, Social and Health Committees of the Parliament	Consensus is reached on the priority issues in a phased manner by December 2002 Domestic Violence Bill is passed by end of 2003
2. Process separate comprehensive bill through government sector as a supplementary activity to the Muluki Ain amendment abortion bill through government sector and carry out advocacy through mass media to address unsafe abortion issues - Draft the bill - Lobby for passage of the bill - Ensure that regulations are approved and passed - Carry out advocacy through mass media - Ensure provision of safe abortion services	On-going	FHD, SM Network, NGOs	Abortion Bill is passed by end of 2003

3. Advocate and lobby to promote compulsory girls' education up to SLC through increase the number of scholarships, provisions for nutritional food and book support - Analyze the current budgetary allocation for girls' education and lobby with MoE and NPC for increase in this amount	-- On-going --	MoE, MoH	Increase in budgetary and other resource allocation for girls' education Strict monitoring carried out on a regular basis
4. Advocate in MOE to incorporate the issues of minimum age of marriage, status of women and SM issues (danger /emergency signs and health care during pregnancy) in the secondary education and non formal, adult literacy classes			
5. Incorporate agenda of raising women status in the existing RHSC (broader issues related to maternal death/abortion bill etc.) - Lobby and sensitize RHSC to adopt VAW as a priority health agenda	-- On-going --	FHD, SM Network, NGOs	RHSC endorses by December 2002
6. Utilize SM Network as a platform for raising women status and reducing maternal mortality - Expand the Network into districts - Develop package on gender discrimination, women's RH and rights (with focus on SM) and VAW and integrate in existing programs for income generation, women's empowerment etc. - Use various media (movies, others) while delivering messages/services related to raising the status of women - Use health facilities to promote awareness and programs on women's rights - Use International Women's Day and other related women's festivals to impart messages on women's rights, SM and gender issues Integrate awareness on SM and women's health in programs like PCRW	-- On-going --	SM Network with support from GO, NGOs and EDPs	Package developed and tested by December 2001 Package being used from January 2002 Number of districts with SM Network

7. Establish linkages with existing women's savings and credit groups and users' groups to promote women's empowerment, RH and rights, with focus on SM - Identify effective saving and credit programs - Develop basic and simple packages Create awareness on the need to spend on women's health and other needs	Package development by December 2001 -- On-going --	SM Network (for coordination) FHD, DHO, MLD and EDPs (for implementation)	Package developed and tested by December 2001 Implementation carried out in 13 SM districts
8. Sensitize all political, legal, medical, police force, and related agencies regarding VAW - Strengthen on-going sensitization programs - Provide sensitization to: ➢ Political and social leaders (central and district levels) ➢ Law enforcers (CDO, legal, police) and community ➢ Health system	-- On-going --	MOH in coordination with NGOs (e.g. Alliance on VAW)	Protocol and orientation package developed by July 2002 Number of orientation programs provided
9. Establish violence detection and early warning system in the Ministry of Home Affairs at all levels - Provide support to on-going programs of NGOs through the DHOs - Help to establish VAW community watch groups - Develop mechanisms to protect people who stand up against VAW and rape	-- On-going --	FHD, DHO, Ministry of Home and related NGOs	System in place by 2005 in the 13 SM districts

10. Establish system in hospitals and health facilities to provide support to battered women, with the help of NGOs, CBOs and WDD - Develop protocols and ensure that these are used at all levels Establish mechanism in district hospital and above in coordination with CDO to deal with VAW	-- On-going --	FHD, DHS, DHOs, partner NGOs and EDPs	Protocol prepared by 2003 Reporting system established in number of district hospitals
11. Undertake research to identify and evaluate program lacunae and achievements - Carry out research on suicide among women in reproductive health - Design and implement evaluation system	-- On-going --	SM Subcommittee	Number of research carried out findings utilized to improve the SM program

Annex 1 – Abbreviation

AA	: Anesthetic Assistant
AIDS	: Acquired Immune Deficiency Syndrome
ANC	: Antenatal Care
ANM	: Auxiliary Nurse Midwife
APR	: Annual Performance Review
BEOC	: Basic Essential Obstetric Care
CBO	: Community Based Organization
CBOC	: Community Based Organization Committee
CDO	: Community Development Officer
CDP	: Community Drug Program
CEOC	: Comprehensive Essential Obstetric Care
CHD	: Child Health Division
CPR	: Contraceptive Prevalence Rate
DDC	: District Development Committee
DHO	: District Health Officer
DHS	: District Health Survey
DOE	: Department of Education
DOHS	: Department of Health Services
DPHO	: District Public Health Officer
EDP	: Education Development Project
EOC	: Essential Obstetric Care
FCHV	: Female Community Health Volunteer
FHD	: Family Health Division
FP	: Family Planning
HIV	: Human Immunodeficiency Virus
HMG	: His Majestic Government
HMIDD	: Health Management Information Development Division
HMIS	: Health Management Information Services
HP	: Health Post
HRD	: Human Resource Development
ICPD	: International Conference on Population and Development
IEC	: Information Education And Communication
INGO	: International Non-Government Organization
IPC	: Interpersonal Communication
LSGA	: Local Self-Government Act
MCHW	: Maternal Child Health Worker
MDGP	: Master Degree of General Practitioner
MLD	: Ministry of Local Development
MMMS	: Maternal Mortality Morbidity Study
MMR	: Maternal Mortality Rate
MNH	: Maternal Neonatal Health
MO	: Medical Officer
MOE	: Ministry of Education
MOH	: Ministry of Health
MOPE	: Ministry of Population and Environment
MWSW	: Ministry of Women and Social Welfare
NDHS	: Nepal Demographic Health Survey
NGO	: Non-Government Organization
NHEICC	: National Health Education Information Communication Center
NHTC	: National Health Training Center

NPC	: National Planning Commission
PAC	: Post Abortion Care
PCRW	: Production Credit for Rural Women
PFAD	: Planning and Foreign Aid Division
PHC	: Primary Health Care
PNC	: Post-natal Care
QOC	: Quality of Care
RETA	: Regional Technical Assistance
RH	: Reproductive Health
RHCC	: Reproductive Health Coordination Committee
RHRSC	: Reproductive Health Research Subcommittee
RHSC	: Reproductive Health Steering Committee
RTC	: Regional Training center
SHP	: Sub Health Post
SLC	: School Leaving Certificate
SM	: Safe Motherhood
SMN	: Safe Motherhood Network
SMP	: Safe Motherhood Project
SN	: Staff Nurse
TBA	: Traditional Birth Attendant
TOT	: Training of Trainers
TTBA	: Trained Traditional Birth Attendant
VAW	: Violence Against Women
VDC	: Village Development Committee
WDD	: Women Development Division

Annex 2 - List of Participants

	Name	Designation/Organisation
1.	Dr. L. R. Pathak	Director, FHD
2.	Dr. Chhatra Amatya	Director, Planning and Foreign Aid Division, DHS
3.	Ms. Gyanu Basnet	HMIDD, DHS
4.	Ms. Durga Gurung	NHTC
5.	Ms. Sharda Pandey	Child Health Division, DoHS
6.	Mr. Muneshwor Mool	Planning and Foreign Aid Division, DoHS
7.	Mr. Ramji Dhakal	PHCP, GTZ
8.	Mr. Ishwar Shrestha	PHCP, GTZ
9.	Mr. Anand Tamang	CREHPA
10.	Dr. Geetha Rana	UNICEF
11.	Dr.Pradeep Pyakhurel	UNFPA
12.	Ms. Dale Davis	UNICEF-ROSA
13.	Ms. Susan Clapham	NSMP, DFID
14.	Ms. Hazel Simpson	NSMP, DFID
15.	Ms. Gyanu Shrestha	UNFPA
16.	Dr. Vijaya Manandhar	WHO
17.	Ms. Anne Erpelding	RHP, GTZ
18.	Ms. Munu Thapa	RHP, GTZ
19.	Ms. Tiphaine Bonetti	RHP,GTZ
20.	Dr. Karuna Onta	Safe Motherhood Network
21.	Mr. David Weakliem	UMN
22.	Dr. Beverley Booth	UMN
23.	Mr. Tek Bahadur Dangi	FHD
24.	Mr. Ajit Pradhan	FHD
25.	Mr. R. C. Sinha	FHD
26.	Dr. Ganga Shakya	FHD
27.	Dr. Kritanjali Koirala	FHD
28.	Mr. Devi Pd. Prasai	FHD
29.	Mr. Ramji Tiwari	FHD
30.	Ms. Chandra Rai	MNH Program/ Nepal
31.	Dr. Jim Litch	MNH Program/ Nepal
32.	Dr. Peden Pradhan	MNH Program/ Nepal
33.	Ms Beena Thapa	MNH Program/ Nepal
34.	Mr. Dirgha Raj Shrestha	Engender Health