**Response of Government of Nepal**

**To the United Nations Human Rights Council on a HRBA (Human Rights Based Approach) to Maternal Mortality and Morbidity**

1. *What steps has your Government or organization taken to utilize a human rights-based approach[[1]](#footnote-1) in policies and programmes to eliminate preventable maternal mortality and morbidity, including in the context of humanitarian settings? How has the technical guidance assisted your Government or organization in designing, implementing, revising and/or evaluating such policies and programmes?*

The right to free basic health services, equal access to health services of every citizen and right to safe motherhood and reproductive health of every woman have been ensured by the Constitution of Nepal as the fundamental rights. Article 35 of the Constitution provides that every citizen shall have the right to free basic health services from the State, and no one shall be deprived of the emergency health services. It also provides that every citizen shall have equal access to health services. Moreover, the Constitution provides that every person shall have the right to get information including about his or her medical treatment. Similarly, Article 38 of the Constitution provides that every woman shall have the right to safe motherhood and reproductive health.

The Constitution, under Article 51 (h)(10), directs the State to pursue the policies to increase average life expectancy by reducing maternal and infant mortality rate, while encouraging family planning for population management on the basis of Nepal's capacity and need and under the social justice and inclusion policies and under Article 51 (j)(3), directs the State to pursue a policy to ensure enjoyment of requisite services and facilities at the reproductive stage.

Affirmative government policies and programmes have contributed to bringing the aforementioned positive outcomes on maternal health, including the reduction on maternal mortality. In order to implement the fundamental rights mentioned above, the Right to Safe Motherhood and Reproductive Health Act, 2018 has been enacted. The Act covers quality Family Planning (FP) services with expanded method mix including emergency contraceptive; safe pregnancy and delivery services; and provision of safe abortion services. The Act also has a clause on non-discrimination, transparency, participation and accountability in relation to accessing reproductive health and maternal health care. Furthermore, the Public Health Act, 2018 was enacted focusing on integrated service provision for reproductive, child and maternal health, with emphasis on quality of care and strengthening of referral mechanisms.

Additionally, there is also a clear reference to sexual reproductive health and rights in policies and programs of the Government of Nepal (GoN) with family planning, safe motherhood being one of the top priority programs of the GoN. The Ministry of Health and Population of the GoN has drafted Safe Motherhood and Newborn Health Programme Roadmap which aims to ensure a healthy life and well-being of all mothers and newborns, and is aligned with the SDGs to reduce current maternal mortality rate from 239 to 70 deaths per 100,000 live births. The draft Roadmap has also laid out emergency preparedness and response for maternal and newborn health as one of the outcome areas and has emphasized the need to strengthen response to maternal and newborn health care.

1. *Has the technical guidance assisted your Government or organization in building enhanced understanding of the requirement of a human rights-based approach? If so, please expand upon the impact that such enhanced understanding has for the design and implementation of policies and programmes in this area?*

Yes, UN agencies with the technical lead from WHO provide extensive technical guidance to the GoN in building enhanced capacity and understanding of the requirement of a human right based approach. For example in 2018-19, following WHO recommendations, the GON endorsed the provision of respectful maternity care as one of the cornerstones of the safe motherhood and newborn program in the country and is currently working on standards and guideline for ensuring respectful maternal care in the health care. Family Welfare Division has also initiated maternal and child friendly Hospital Initiatives in some hospitals.

1. *What challenges does your Government or organization face in implementing a human rights-based approach in policies and programmes to eliminate preventable maternal mortality and morbidity? Please elaborate on the nature of these challenges and steps taken to address them.*

Though Nepal has seen a reduction in maternal mortality rates in the last decade, it is estimated that in 100,000 live births 239 women could die from complications of pregnancy and child birth from age 15 to 49. This is a reflection that still the country has not been able to provide women the continuum of skilled care to reduce maternal deaths. Despite the overall progress in maternal health and sexual and reproductive health indicators, inequalities exist and disparities are widening – the utilization rates are still visibly disparate among different sub-regions and among population groups such as adolescents, postpartum women, ethnic/religious minorities and the urban poor. While the policies are responsive to their needs, there is a gap in implementation and in resources. There is a need to improve the quality and access to reproductive health services, particularly for underserved population groups, including those who live in rural and remote areas. There are numerous supply and demand side barriers to access and utilization of Sexual and Reproductive Health (SRH) and maternal and new born health services, including Inadequate numbers of trained human resources, stock out of essential supplies, socio-cultural behavior limiting care seeking behavior.

The Ministry of Health and Population has adopted various strategies to reduce risks during pregnancy and childbirth and address factors associated with mortality and morbidity. The major strategies include promoting birth preparedness and complication readiness including awareness raising and improving preparedness for funds, transport and blood transfusion; expansion of 24 hours birthing facilities alongside ***Aama Suraksha* Programme** (incentives provided for transportation to health facility for ante-natal care and delivery and free delivery services) promotes ante-natal check-ups and institutional delivery; the expansion of 24-hour emergency obstetric care services (basic and comprehensive) at selected health facilities in all districts.

1. *Please provide information on the main areas of concern specifically in relation to maternal morbidities in your country and/or context. Please elaborate on the main causes leading to maternal morbidities in your country and/or context?*

Postpartum haemorrhage (PPH) and hypertensive disorders of pregnancy continue to be the leading causes of maternal deaths, with PPH leading in the communities and hypertensive disorders of pregnancy leading in health facilities. Infection and non-communicable diseases are becoming increasingly important as causes of maternal death. A third of maternal deaths and a substantial proportion of pregnancy related life threatening conditions are attributed to complications that arise during labour, childbirth or the postpartum period.

1. *Is there particular group of women and girls who are more at risk of maternal morbidities? (For instance, adolescents, women living with HIV, indigenous women, women of African descent****,****women from rural areas etc.)*

Underserved population groups such as adolescents, women living in rural and remote area, women of low socio-economic status including among the uneducated, ethnic and religious minorities are at a greater risk of maternal morbidities.

Adolescent mothers face higher risks of complications and babies born to young mothers have a greater risk of low birth weight with potential long-term effects. Although fertility has been falling in Nepal, adolescent birth rate increased from 81 in 2011 to 88 in 2016 per 1000 women. Contraceptive use among married 15 -19 years is very low (14.5% for modern contraceptive methods). Repeat pregnancy and short intervals between births is also a concern for young mothers and presents further risks to both the mother and the child. Deliveries conducted by a skilled provider have increased from 36% in 2011 to 58% in 2016. Still (in 2016), 41% of women gave birth at home, with the highest home births occurring in Province 6 (63%) and in Province 2 (55%). Similarly, 34% of women in the poorest wealth quintile had an institutional delivery compared to 90% in the highest wealth quintile. Women with no education are less likely to deliver in a health facility than women with secondary or higher education (36% and 85% respectively).

1. *What type of measures are in place to prevent maternal morbidity, including laws, policies and programmes? How has a human rights-based approach informed such measures?*

Nepal took an integrated approach to community health and family planning programmes in the early 1960s that led the way for safer motherhood. The Safe Motherhood Programme commenced in 1997 under the Second Long-Term Plan (1997-2017) which emphasized strengthening of infrastructure for the delivery of reproductive health services. The National Safe Motherhood Plan 2002-2017 aimed to have functioning comprehensive emergency obstetric and newborn care (CEONC) sites in 63 districts and functioning basic emergency obstetric and newborn care (BEONC) facilities in 137 Primary Health Centres by 2017, and health posts with skilled attendants increased to 90 % by 2017. It was revised in 2006 as the National Safe Motherhood and Newborn Health Long-Term Plan (2006-2017) which strengthened the component of newborn health care. The National Family Planning Implementation Plan (2015-2020) was launched to boost the family planning programme and to ensure access to rights-based family planning services. The policy on skilled birth attendants (SBAs) was endorsed in 2006, which identified the importance of skilled birth attendance at every birth. The Safe Delivery Incentive Programme was introduced in 2005 to promote delivery by skilled birth attendants, by providing cash as transport support cost to women giving birth in a public health facility. This Programme evolved into the Aama Programme in 2009 which extended it to provision of free delivery care at public and some private facilities. Since 2016, free newborn care has also been included in the Programme. Furthermore, abortion was legalized in 2002 and implementation of services at public facilities began in 2004.

The Social Health Insurance Scheme was formally launched in 2016/17 and will be gradually expanded nationwide, and allows for partnerships with private sector organizations and includes maternity care services as well. The Safe Motherhood and Reproductive Health Act, 2018 guarantees reproductive rights of every woman. The Public Health Act, 2018 focuses on integrated service provision for reproductive, child and maternal health, with emphasis on quality of care and strengthening of referral mechanisms.

National Health Policy, 2019 has included “ Developing and expanding safe motherhood and child health, adolescent and reproductive health and elderly health care services in the life course approach” as one of its policy statements and covers one skilled birth attendant in each ward, expanding professional midwifery and nursing service, etc as its strategies among others. Similarly the Approach Paper of 15th five year plan of Nepal (2019/20 – 2024/25), includes the life course approach as one of its strategy under social sector (Health and Nutrition; which covers Evidence based Midwifery education and other especial programs to reduce maternal mortality; Free screening for increasing of cervical and breast cancer, among others. It expects to decrease the maternal mortality ratio to 99 by end of the five years period.

Nepal Health Sector Strategy (NHSS) (2015-2020) also defines health care as being qualitative when it is effective, safe, client-centered, timely, equitable, culturally appropriate, efficient and reliable. Health Institution Quality Assurance Authority Act is being drafted including the provisions for the establishment of an autonomous body for accreditation of private (including NGO) health institutions, and various quality improvement programmes are being implemented across health facilities.

1. *What measures are in place to support women and girls affected by maternal morbidities, including targeted programmes aiming at addressing their specific needs?*

Ministry of Health and Population/Family Welfare Division is promoting inter-sectoral coordination and collaboration at Federal, Province, District and local levels to ensure commitments and action for promoting safe motherhood with a focus on poor and excluded groups. Nepal is strengthening and expanding delivery by skilled birth attendants and providing basic and comprehensive obstetric care services at all levels. These interventions include developing the infrastructure for delivery and emergency obstetric care; standardizing basic maternity care and emergency obstetric care at appropriate levels of the health care system; strengthening human resource management —training and deployment of advanced skilled birth attendants (SBA) anesthesia assistants and establishing a functional referral system with airlifting for emergency referrals from remote areas, and the provision of emergency referral funds in all remote districts. Furthermore, Nepal has introduced midwifery education in the country and the first batch of midwives will graduate in 2020. Community level maternal and newborn health interventions include awareness on birth preparedness and distribution of *matri suraksha chakki* (misoprostol) to prevent PPH in home deliveries and complication readiness through Female Community Health Volunteers (FCHVs) and increasing access to maternal health information and services.

***Aama Program***

In Nepal, antenatal care, postnatal care and the care during delivery, including the management of any complications, are free and part of the Basic Health Service (BHS) Package that is provided by the Local Government. Services which are beyond the scope of the BHS package are delivered though different health protection arrangements, including the Social Health Insurance which was introduced by the GoN in 2015, and th*e Aama* Programme. In 2005, the GoN introduced a maternity incentive scheme that provides money to women to subsidize transport costs to reach a health facility for birth. This has evolved into a package, called the *Aama* Programme (2006), that also provides free care for normal deliveries, obstetric complications and caesarean section and an incentive for having a facility delivery and completing 4 antenatal care visits.The *Aama* Programme has been associated with an increase in facility delivery in all parts of the country. This program is complemented by the demand-side interventions to encourage women for institutional delivery. Furthermore, the free newborn care programme has been merged with the *Aama* Programme.

***Matri Surakshya Chakki***

The GoN has continued to expand and maintain maternal and new born health activities at community level including the Birth Preparedness Package and distribution of *matrisurakshachakki* (misoprostol) to prevent PPH in home deliveries. For home deliveries, three misoprostol tablets (600 mcg) are handed over to pregnant women by FCHV at 8th month of pregnancy through proper counselling to take immediately after delivery and before the placenta is expelled. A total of 50 districts are currently implementing the programme.

1. *Does your Government or organization regularly collect and analyse disaggregated data and information on maternal morbidities? Please elaborate on good practices and challenges in this regard.*

Yes, The routine health management information system (HMIS) collects data on maternal mortalities and morbidities. The data includes number of maternal mortality, maternal morbidities, services provided for FP, safe abortion services, post abortion care, post-partum FP. The data is analysed and reports are disseminated annually.

The GoN has established maternal and perinatal death surveillance and response at the hospital and community levels in order to identify, review and respond to the preventable maternal and perinatal mortalities. The aim of the program is to help eliminate preventable maternal and perinatal mortality. Information of the deceased mother is collected which includes demography, clinical conditions, delays in seeking, reaching and receiving care and cause of deaths. At the hospital and community levels responses are implemented based on the review of the deaths.

1. [↑](#footnote-ref-1)