ROYAL GOVERNMENT OF BHUTAN

ACCELERATING MATERNAL AND CHILD HEALTH POLICY

1000 Days Plus

Ministry of Health

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Acronyms

AMCH:	Accelerating Maternal and Child Health
ANC:	Antenatal Care
ATM:	Automated Teller Machine
BHU:	Basic Health Unit
CCT:	Conditional Cash Transfer
DHI:	Druk Holdings and Investment
DHO:	District Health Officer
DoPH:	Department of Public Health
HF:	Health Facility
IMR:	Infant Mortality Rate
JSSY:	Janani Shishu Suraksha Yojana
MCH:	Mother and Child Health
MNE:	Monitoring and Evaluation
NCDD:	Non-Communicable Disease Division
NCWC:	National Commission for Women and Children
NKRA:	National Key Result Area
NMR:	Neonatal Mortality Rate
NNS:	National Nutrition Survey
OM:	Operations Manual
PHCB:	Population Housing Census of Bhutan
PMIS:	Project Management Information System
PNC:	Post Natal Care
RMNHP:	Reproductive Maternal and Child Health Program
SDG:	Sustainable Development Goal
SDIP:	Safe Delivery Incentive Program
TFR:	Total Fertility Rate
VHW:	Village Health Worker
WHO:	World Health Organization

1. Policy Name

Accelerating Mother and Child Health Policy

2. Rationale

Maternal mortality ratio in Bhutan is estimated at 89 per 100,000 live births (PHCB, 2017), and the maternal health care utilization is far from optimum. Only 25.9 percent of the pregnant women report completing the recommended 8 Antenatal care visits (NNS, 2015). The report also revealed that both urban (31.1%) and rural (21.4%) reported low coverage of recommended 8 antenatal care visits. Furthermore, about half the pregnant women in our country do not come to register their pregnancies until after the first trimester – which results in women missing out some critical services in the early phase of their pregnancies (PHCB, 2017). Likewise, the Post Natal Care (PNC) coverage for any visit stands at 77.7% (NNS, 2015). However, the coverage of 4 complete PNC visits is below the optimum level. In addition, the administrative data maintained at Ministry of Health (MoH) also indicate high proportion of mothers not completing the 4 complete crucial post-natal care services as well. Other essential indicators for the maternal and child health such as anemia prevalence among pregnant women that is 25.9% and stunting for Children Under 5 with 26.1% as reported by NNS, 2015 is also a big concern for Bhutan.

The underutilization of maternal health services during pregnancy, for delivery and at the post-natal period are important contributors for high maternal and neonatal mortality rates in many developing countries including Bhutan. Currently the Neonatal Mortality Rate (NMR), Infant mortality rate (IMR) and Children under five mortality rate stands at 21, 15.1 and 34.1 per 1000 live births respectively (PHCB, 2017). This is a cause of concern as Bhutan accords high priority in ensuring the survivability of every fetus and newborn especially in light of the reducing Total Fertility Rates (TFR).

Consequently, providing comprehensive and quality maternal and child healthcare in the country has become one of the priority national agendas. In the 12th Five Year Plan (2019-2023), targets for maternal and child health constitute some of the most important components of the National Key Result Area (NKRA). Furthermore, Bhutan is also committed to the global Sustainable Development Goals (SDGs) which has specific targets for maternal and child health.

In order to accelerate the improvements in the maternal and child health, optimum utilization of health services has been identified as one of the key strategies.

Demand-side programming that looks at providing incentives to avail the necessary health services have been known to work in many settings. For example, Janani Shishu Suraksha Yojana (JSSY) in India which looked at improving access to care during pregnancy and in the postpartum period by providing cash based on certain conditions increased the number of institutional deliveries by 43%. Similarly, Nepal's Safe Delivery Incentive Program (SDIP) which aimed at encouraging greater use of professional care at childbirth by providing cash to women giving birth in a public

health facility, and incentives to the health provider, also saw significant increases in the skilled birth attendance.

Similar demand-side programming, which will optimize the utilization of existing services in Bhutan is needed to accelerate the improvements in the maternal and child health. A conditional cash transfer program (CCT) that provides certain monetary incentives for mothers, who avail the requisite maternity and child health services will accelerate the outcomes for maternal and child health. Hence, AMCHP is envisioned to be an intervention that will facilitate the Ministry in achieving the last mile. Likewise supply side from the Ministry will also be improved where in, the MCH services will be made accessible, available and of acceptable quality.

3. Current Policy Options/Approaches

Currently, the Ministry of Health provides Mother and Child Health Services from all levels of health facilities in the country. The services are provided by the Health Assistants of the Mother and Child Health Unit (MCH). The MCH unit is mandated to provide all the essential services for pregnant women, mother and child as per the MCH guideline developed by the Ministry of Health. The study on Reaching the Unreached (2016) also revealed that all hospitals and BHUs were adequately equipped to provide full range of essential health services, and MCH is one of the essential health services. In addition, the study also found that majority of the population in Bhutan were well covered by the health service network except for some pockets of population owing to their nature of lifestyle. Despite concerted and continuous effort from the government in encouraging pregnant women and mothers to seek health care during and after delivery, the country still lags behind in indicators such as exclusive breastfeeding rate (51%), and the coverage of recommended 8 ANC (26%) and 4 PNC visits (75%) as revealed by National Nutrition Survey (2015).

Furthermore, health education and advocacy on the importance of utilizing the MCH services through various media outlets, and at the local government level have still not been able to completely instill in the importance for a vast majority of the population in rural areas, including people from low socio-economic status.

The low utilization of MCH services can largely be attributed to the following as per the findings of the studies carried out in Bhutan:

I. **Distance from the health facility**: Proximity to health facility is an important factor in accessing health services, in particular, the MCH services (*Karki, 2015 and Ugen, 2016*). Likewise, both the study also points that access to road will not guarantee utilization of health services, the availability of vehicle or transport also plays an important factor.

II. **Nature of Occupation:** The health seeking behaviors of the daily wage earners and road construction laborers is mostly influenced by the work timing and work policies like wage

cuts in case of absence (*Ugen, 2016*). Hence, it deters them from accessing the existing health services.

III. **Financial Burden**: The indirect costs associated mainly in transportation to the nearest health facility is a deterrent factor for those living far away from the health facility to utilize the services (*Karki, 2015 and Ugen, 2016*). Furthermore, it is also found that rural households spends three times more in transportation for health care than urban.

IV. Competing priorities such as household chores and farm works: The inability to take time off from farm work and domestic responsibilities takes precedence over health care access and utilization (*Ugen, 2016*).

V. Social and Cultural beliefs: Cultural practices are still at the core of health belief system among the population in remote areas, where people rely on traditional medicine, shamans, priests, and local healers (*Ugen, 2016*). Further, health seeking behavior and utilization of services is influenced by the local cultural practices and beliefs of the community (*Babra-Ari et al, 2018*).

VI. **Family Pressure**: Family members are influential advisors on health seeking behaviors and self-care practices. Likewise spousal influences also play an important role in the utilization of services (*Karki 2015 & Babra Ari et al, 2018*).

VII. **Health Education and Information**: There is a need to scale of information and advocacy program as some of the Bhutanese women are deprived of knowledge on their susceptibility during pregnancy and childbirth, and in turn it also questions the quality of ANC (*Karki, 2015*).

The current policies despite providing equal platform for all, however, does not consider the factors as noted above to enable them to utilize the MCH services. Furthermore, there are no concrete policies, which provides enabling conditions for vulnerable pregnant women, mothers and children, and also for those who are unreached to utilize MCH services on a regular basis.

Recognizing the need to have a policy that is responsive and inclusive towards the needs of these women including family members, the Ministry of Health through the Accelerating Mother and Child Health Policy will be positioned to address these issues. Moreover, the policy is also intended to provide a holistic and comprehensive approach towards increasing the uptake of MCH services through the provision of conditional cash transfers. This will also ensure that there is an equitable access to MCH services; where by a child born in rural area will be provided the same services as that of a child born in an urban area.

4. Legal and Policy Environment

The National Health Policy, the Mother and Child Health Guideline and other legislative frameworks including the regional and global commitments have influenced the way in which this 'Accelerating Mother and Child Health policy has been formulated and the way in which it will be implemented.

4.1 Existing Policy and Regulations

- The Constitution of the Kingdom of Bhutan mandates the state to provide free basic health care to all Bhutanese and the preventive and primary health care services are a major thrust in the Bhutanese health system.
- The National Health Policy (2011) and Food and Nutrition Security Policy of the Kingdom of Bhutan (2014) both promote quality maternal and child health and nutrition through comprehensive quality health services and cross sectoral strategies.
- The Ministry of Health has developed National Reproductive Health Strategy (2018-2023), Bhutan Every Newborn Action Plan (2016-2023), which aspires to accelerate reductions in the maternal and child morbidity and mortality. The CCT for mothers in Bhutan, is in line to the national policies that will contribute to accelerating the improvements in the maternal and child health outcomes.

4.2 Regional Commitment

- South-East Asia Regional Parliamentarians' Meeting, which was held in 2018 to renew and enhance political commitment and engagement of Parliamentarians on Reproductive, Maternal, Neonatal, Child and Adolescents Health. In addition, to renew the commitment towards ending preventable maternal, newborn and child mortality in the Region.

4.3 Global Commitment

- The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) urges the political leaders and policy makers to further accelerate their work to improve the health and wellbeing of women and children. The strategy also envisions to ensure that every woman, child and adolescent in every setting realizes their rights to physical and mental health and well-being, has social and economic opportunities, and is able to participate fully in shaping prosperous and sustainable societies.

- SDG 3: Ensure healthy lives and promote wellbeing for all at all ages (3.2), it underscores that by 2030, preventable deaths of newborns and children under 5 years of age to be ended, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births.

5. Recommended Options/Approaches

The data derived from researches in different countries indicates supply-side interventions alone are not sufficient to adequately increase uptake of healthcare services if demand side limitations, such as the population's poverty level, transportation costs to reach a health center and others are not taken into consideration (Ari F et al, 2018). Likewise, the annual surveys and data maintained at the Ministry of Health also indicates that uptake of MCH services is far from optimum level owing to the demand side limitations. Karki (2015) also suggests in introducing cash incentives for mothers to cover transportation and non-medical consumable costs while visiting the health facility. Therefore, the Accelerating Mother and Child Health policy will ride on the provision of Conditional Cash Transfers (CCT) to the eligible pregnant women and mothers with children less than two years of age.

The provision of CCT is expected to increase the utilization of MCH services in the country. However, it will also be noted that the provision of cash may not fully increase the utilization of MCH services, the policy will also ensure that the MCH services are available, accessible and of acceptable quality to target recipients and will have a robust communication strategy in place to improve the health seeking behavior, knowledge and practices for MCH services.

Furthermore, the AMCH policy is also envisioned to be an investment for future generations and hence, it will encompass the socio-economic dimensions such as:

I. Financial empowerment for women by enabling them to operate their own personal saving bank account
II. Economically active and healthy future generations
III. Shared responsibility of the spouse, family and community
IV. Human Capital factor adjustment, taking into account the unpaid care work most devoted by women of child bearing age between 25-34 years.

The AMCH policy will also ensure that it will focus on increased uptake of key evidence based interventions of the following:

- WHO recommended 8 ANC visits;
- Institutional Delivery;
- WHO recommended 4 PNC visits;
- Immunization;
- Exclusive breastfeeding for 6 months;
- Ensure early detection and timely intervention in cases of complications during pregnancy and illness of the mother or infant/child;

- Promote better nutrition including the provision of Micro-nutrient powder (MNP) and development/growth of the infant/child;
- Ensure early detection of developmental delays and initiation of appropriate management (treatment and care).

5.2 Outcome achievement incentivized through:
(a) Conditional cash transfers (to reduce income constraints); and,
(b) Tailored information campaigns and messaging (to improve health-seeking knowledge, practices and behaviors).

6. Implementation Procedure

6.1 Delivery platform

The MCH clinics will be the main delivery platform for implementing the program. The **key target beneficiary population** will be identified by the health workers during the first registration of the pregnancy in the MCH clinics. The MCH clinics will provide quality MCH services to all mothers. In addition, the Ministry of Health will develop an Operations Manual (OM) which will provide detailed guidelines to implementers of the AMCHP, at central and decentralized levels.

At the central level:

- Program management shall be the responsibility of the Department of Public Health (DoPH), Reproductive Maternal Newborn Health Program (RMNHP), Non-Communicable Disease Division (NCDD).

Health Facilities:

- Delivering services to women and children; both directly and through outreach services
- Recording the first booking- and information related to all visits in the MCH tracking system, or manually, where this online system does not exist
- Administrative enrolment in the PMIS and program information pertaining to all subsequent visits.

Health Professionals:

- Collecting and entering the relevant data in the PMIS
- Explaining the conditions of the program to the potential beneficiary
- Supporting the beneficiary in opening a bank account, in case she does not already have one.
- Providing the services as per the MCH guideline

Dzongkhag Health Officer:

- The DHO is responsible for overseeing the implementation of cash transfers in his/her Dzongkhag, including the monitoring and evaluation.

Village Health Workers:

- The VHW is responsible for communication and outreach activities at the village level.
- In the case of bottlenecks/ challenges that need to be addressed in order for a visit to take place (e.g. absence of transport), the VHW should discuss these with the DHO/ health facility staff as appropriate.
- Is also responsible for explaining the AMCHP to the communities as far as possible.

Banks:

Banks play an important role in the program, as it is expected that most transfers will reach beneficiaries through the banking system. Banks should guarantee that:

- Beneficiaries are able to withdraw their payments within a stipulated timeframe; and
- Cash dispensing machines like ATMs are always in condition to deliver cash to the beneficiaries; and
- Other options as deemed appropriate by Banks

6.2 Key Target Beneficiary Population

The target for the conditional cash transfer will include

- All the mothers who are not entitled to six months paid maternity leave including those mothers in private and corporate sectors.
- In case of paid maternity leave of less than 6 months, the total benefit amount will be pro-rated, taking into account the number of months of paid maternity leave.

There are approximately 10,000 births per year in Bhutan, resulting in 833.33 new pregnancies every month. Beneficiaries will stay in the program a maximum of 7 months (during pregnancy, considering that no woman will be enrolled and receive benefits until the end of her second month of pregnancy) and a further 24 months after delivery, i.e. a total of 31 months. Since the program will enroll and transfer benefits to pregnant women and mothers with children under 24 months of age, the program will have, at any point in time, the following number of beneficiaries:

833.333 x 31 months = 25,833 beneficiaries

The program will therefore have to manage, every month, benefits and compliance for an average of 25,833 beneficiary pregnant women and mothers.

With the implementation of the program, it will be expected that 90% of the total beneficiaries will have completed all the visits.

6.3 Disbursement Modality

- The uptake of MCH services will be used as a basis to determine if a woman is eligible to receive the conditional cash transfer.
- A validation document will have to be endorsed by the health facility to ensure that the criteria detailed for eligibility of this conditional cash transfer has been fulfilled before the fund is disbursed.
- The conditional cash transfer will be disbursed in definite disbursement periods after the fulfillment of the defined criteria by the eligible mothers. In order to ensure that the mother and child are cared for from conception until the child is two years, the disbursement will be spread from conception until the child is two years old.
- The conditional cash transfer will be disbursed using mix methods, that is, pay roll and cash transfers after fulfillment of conditions.
- After the registration and enrollment with the program, Nu. 1000 will be disbursed es account. The same amount will be disbursed until the completion of 8 ANC visits. This amount will not be viewed as an income but rather to enable or facilitate the beneficiaries to visit the health facilities using this amount.
- Starting from institutional delivery, Nu. 4000 will be disbursed until the child is of 6 months, the increase in the amount can be a substitute for income as the mothers can provide extra care and generally, this period requires extra care.
- After the child attains 6 months, the beneficiaries will again receive Nu. 1000 until the child is of 2 years of age.
- The conditional cash transfer shall be considered as income and be taxable in line with the taxation legislation in place.

Drawing que from the six months paid maternity leave for the public servants; the amount for conditional cash transfer is calculated for six months. The amount will be disbursed in 21 tranches from the 25 visits that the beneficiaries will be required to make to the health facilities.

Amount to be disbursed during the disbursement period works out to Nu 39000 for each delivery.

The overall program budget for the AMCHP is as follows:

- Considering the total live births and the national minimum wage rate (Nu. 286/day), the total estimated budget required is as follows:
- Total Bhutanese population = 681,720
- Total birth in 2017 = 11,239
- Population birth ratio = 61:1
- Total civil servants = 28,973
- Approx. birth by civil servants = 475 (Assuming the ratio of 61:1 population birth ratio as a proxy)
- Approx. birth by DHI companies employees (30% civil servants) = 143
- Remaining 11,239 – (475 + 143) = 10,621
- CCT for each delivery is Nu.**39000** (25 visits from conception till child is 2 years old; 21 CCT tranches @ Nu.4000 for 6 months from delivery till child months, and @Nu.1000 for the remaining visits)
- The total budget required for one year is Nu. **414.99** m and in one plan period Nu. **2.074** billion

7. Monitoring and Evaluation

In line with the National Monitoring and Evaluation framework, it will consist of three elements: (a) program process, where the coverage report by the program managers for keeping record, strategizing and progress monitoring; (b) Output level indicators that needs reporting for the 12 FYP and; (c) Outcome level indicators for the both the 12FYP and 2030 SDG.

The data for the outcome and output level indicators will be derived from national survey reports or equivalent reliable data sources that has national data representations. The outcome indicators will be reported 2023 and 2030 corresponding to the reporting periods of the 12 FYP and SDGs respectively; while the output indicators will be reported once in 2023.

The process of the program will be monitored through the process indicators which will be managed by the program managers of DoPH. The data from the field will be managed by the DHOs and focal persons (in case of HFs which are autonomous or under the direct supervision of MoH); and a report on the coverage will be submitted to program managers of DOPH every 6 months.

8. *Clause Review and Revision of Policy*:

Periodically, the Ministry of Health will conduct a review and decide on when the program has achieved the desired target.

Table 1: Monitoring and Evaluation Framework

	INDICATOR	BASELINE What is the current value?	TARGET What is the target value?	Accelerated PROGRAM TARGET	DATA SOURCE	FREQUENCY How often will it be measured?	RESPONSIBLE Who will measure it?	REPORTING Where will it be reported?	DATA SOURCE How will it be measured?
Outcomes	Maternal Mortality Ratio (MMR)	89 per 100,000 live births	83/ 100,000 LB in 2023 and 70/100,000 LB in 2030	83/ 100,000 LB in 2023	PHCB 2017	In 2023 & 2030	Program managers, MoH	GNHC (report for 12 FYP &SDGs)	National Level Surveys or equivalent
	Neonatal Mortality Rate (NMR)	21 per 1000 live births	13.2 /1000 LB in 2023 & 12/1000 LB in 2030	13.2 /1000 LB in 2023	NHS 2012	In 2023 & 2030	Program managers, MoH	GNHC (report for 12 FYP & SDGs)	National Level Surveys or equivalent
	Under 5 mortality rate	34 per 1000 live births	20.3/1000 LB in 2023 & > 20.3/1000 LB in 2030	20.3/1000 LB in 2023	PHCB 2017	In 2023 & 2030	Program managers, MoH	GNHC (report for 12 FYP & SDGs)	National Level Surveys or equivalent
Outputs	Immunization coverage	95%	>95%	>97%	NHS 2012	Once in 2023	Program managers, MoH	GNHC (report for 12 FYP)	National Level Surveys or equivalent
	Institutional delivery rate	93.4%	>90%	>95%	PHCB 2017	Once in 2023	Program managers, MoH	GNHC (report for 12 FYP)	National Level Surveys or equivalent
	Proportion of pregnant women who complete all 8 ANC visit	26 %	40%	>60%	NNS 2015	Once in 2023	Program managers, MoH	GNHC (report for 12 FYP)	National Level Surveys or equivalent
	Proportion of women who complete all 4 PNC visits	75%	90%	>90%	NNS 2015	Once in 2023	Program managers, MoH	GNHC (report for 12 FYP)	National Level Surveys or equivalent
	Proportion of children 0-6 months who are exclusively breastfed	51%	56%	>70%	NNS 2015	Once in 2023	Program managers, MoH	GNHC (report for 12 FYP)	National Level Surveys or equivalent

	Early Initiation of Breastfeeding	78%	90%	>90%	NNS 2015	Once in 2023	Program managers, MoH	GNHC (report for 12 FYP)	National Level Surveys or equivalent
	Proportion of women who know the recommended duration of exclusive breastfeeding for their child	-	>90%	>90%	-	Once in 2023	Program managers, MoH	Survey reports (comments: this is not a 12FYP indicator	National Level Surveys or equivalent
	Proportion of women who received counselling on maternal nutrition during any period of their pregnancy	-	>90%	>90%	-	Once in 2023	Program managers, MoH	Survey reports (comments: this is not a 12FYP indicator	National Level Surveys or equivalent
Program process Indicators	Proportion of eligible women who get conditional cash transfer	0	100%	100%	-	Biannually	DHOs/ focal persons in case of HFs which are autonomous or under the direct supervision of MoH	Program managers, MoH	Program reports

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