



Nepal Safer Motherhood Project

a part of HMGN Safe Motherhood Programme

CHALLENGES TO REDUCING MATERNAL MORTALITY *Experiences from the three districts in Nepal supported by the Nepal Safer Motherhood Project - Kailali, Surkhet and Baglung*

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support by the
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and Baglung**

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ABBREVIATIONS

ANC	Ante-natal Care
ANM	Auxiliary Nurse Midwife
BEmOC	Basic Emergency Obstetric Care
BTS	Blood Transfusion Service
CEmOC	Comprehensive Emergency Obstetric Care
COPE	Client-Orientated Provider-Efficient
CS	Caesarean Section
DFID	Department for International Development
DHO	District Health Office
DHSP	District Health Strengthening Project
DPHO	District Public Health Officer
EOC	Emergency Obstetric Care
FHD	Family Health Division
HMGN	His Majesty's Government of Nepal
HRDO	Human Resource Development Officer
IAC	Increasing Access Component
IEC	Information, Education and Communication
INF	International Nepal Fellowship
IP	Infection Prevention
JSI	John Snow International
MASS	Management Support Services
MIRA	Mother Infant Research Activities
MSD	Medical Supplies Department
NBTS	National Blood Transfusion Service
NFCC	Nepal Fertility Care Centre
NGO	Non-Governmental Organisation
NHEICC	National Health Education, Information and Communication Centre
NHTC	National Health Training Centre
NSMP	Nepal Safer Motherhood Project
PAC	Post Abortion Care
PNC	Post Natal Care
PPH	Post Partum Haemorrhage
QoC	Quality of Care
SCF/(UK)	Save the Children (United Kingdom)
SMP	Safe Motherhood Programme
TAP	Technical Assistance Programme (INF)
TBA	Traditional Birth Attendant
ToRs	Terms of Reference
TTA	Technical Training Adviser (NSMP)
WHO	World Health Organization
WRH	Western Regional Hospital

WHO IS THIS BOOKLET FOR?

This booklet is primarily for donors, International Non-Governmental Organisations (INGOs), Non-Governmental Organisations (NGOs) and government health services - in fact, all those who are engaged in supporting change within health services in Nepal.

It will also be of value to the Nepal Safer Motherhood Project (NSMP) when the project expands beyond the three project districts in which it is currently working. It may also be of interest to other non-NSMP supported districts who would like to improve the services they provide.

WHAT IS THIS BOOKLET ABOUT?

NSMP has been supporting improvements in the quality of maternity services in three district hospitals for sixteen months. The focus of one component of the project has been on improvements in the provision of emergency obstetric care (EmOC). What was not anticipated in the original project design was the number and variety of other aspects of the hospital and its service which would have to be addressed before any improvements in EmOC could be achieved.

This booklet documents the many issues the project had to address. Activities, strategies and achievements are described, and lessons drawn from the experience of the project.

Many projects attempt to bring about change and improvements, but their experiences are rarely recorded in a way which will be of value to others undertaking similar tasks. This booklet is an attempt to document the experiences of NSMP in a way that will be of benefit to others.

WHAT IS THE NEPAL SAFER MOTHERHOOD PROJECT?

The Nepal Safer Motherhood Project is funded by the UK Department for International Development (DFID) and is being implemented by Options Consultancy Services Limited, a UK-based consultancy company specialising in reproductive, sexual and maternal health. NSMP supports His Majesty's Government of Nepal's (HMGN) Safe Motherhood Programme. The goal of NSMP is to contribute to HMGN's objective of reducing maternal mortality in Nepal. The specific purpose of NSMP is to "increase utilisation of and access to quality emergency obstetric life saving care".

The project has two main components:

SERVICE PROVISION - under which the capacity to provide quality emergency obstetric care within rural areas is increased. This includes improvements to the physical infrastructure of hospitals, provision of equipment and supplies, and improved performance of personnel.

INCREASING ACCESS - under which awareness of and demand for services is promoted through community participation so that women whose health may be at risk as a result of complications which occur during pregnancy, childbirth, or the post natal period, have the capacity to use the available services.

This document is concerned with the first component - **service provision**. It documents how NSMP has faced the challenge of supporting improvements in quality of care and EmOC services in three districts - Baglung, Kailali and Surkhet.

BRIEF HISTORY OF THE PROJECT

The scope for a substantial involvement in the health sector in Nepal was identified by DFID (then ODA) as early as 1993. A subsequent health sector strategy mission identified reproductive health services as a priority area with emphasis on promoting safer motherhood. This mission was followed by a detailed inventory of the safe motherhood capacity in proposed districts, a feasibility study (January 1995) and an appraisal mission (September 1995). The project design was based on these studies.

The proposed project duration was six years including an inception phase from March to December 1997. This would be followed by two phases; Phase One (two years) in three districts; and Phase Two, expansion to other districts, the number to be determined following review of the first phase.

The Project had been fully operational for approximately sixteen months at the time of writing this document.

WHERE DOES THE PROJECT OPERATE?

Three of HMGN's Safe Motherhood Districts were selected by NSMP for implementation during the first phase of the project. These districts represent different geographical areas.

Baglung is in the hilly district in the Western Region. The hospital has a budget for 15 beds serving a population of some quarter of a million. Comprehensive Emergency Obstetric Care (CEmOC) is not available in Baglung and patients needing caesarean sections must travel to Western Regional Hospital in Pokhara, some two hours' drive away. The population of Baglung is ethnically mixed.

Surkhet is a mid-western, inner Terai district with a population of a quarter of a million, including many low-caste, marginalised people. The hospital supports 15 beds and CEmOC is provided only when the surgeon is available.

Kailali is in the far west, bordering India. Seti Zonal Hospital serves as a referral centre for a number of neighbouring districts and has a budget for 40 beds. CEmOC is provided here, but again only when a surgeon is available. The population of half a million is made up largely of Tharu people, most of whom do not speak Nepali.

REPRODUCTIVE HEALTH IN NEPAL?

There are several agencies involved in reproductive health in Nepal:

1. Government Health Services

In 1993 HMGN established a Safe Motherhood Task Force, developed a National Plan of Action and a programme for 10 districts. This programme is co-ordinated by the Family Health Division (FHD) of the Department of Health Services. The FHD is the counterpart division for NSMP. In addition NSMP collaborates with other government divisions - notably the National Health Training Centre (NHTC) which is responsible for in-service training and the National Health Education, Information and Communication Centre (NHEICC).

2. Donors, INGOs and NGOs

Numerous donors, INGOs and NGOs are involved in reproductive health activities. For example, UNFPA is mainly concerned with the provision of family planning services and supplies, though recently they have sponsored the development of reproductive health protocols and an important Maternal Mortality and Morbidity Study; DFID supplies Depo-Provera to UNFPA and funds NSMP; WHO funds overseas observation tours and EmOC training for doctors and nurses in India and Nepal; UNICEF funded the development of the National Maternity Care Guidelines and developed IEC materials for safe motherhood; KfW/GTZ have recently initiated a reproductive health project, which will include safe motherhood, in three districts.

USAID funds a number of organisations with a role in some aspect of reproductive health:

- JHPIEGO is mainly involved in pre-service training in family planning, the development of reproductive health medical standards and protocols, and in-service training for post abortion care (PAC)
- AVSC concentrates on family planning and quality of care issues
- FHI addresses high risk groups in HIV/AIDS/STD
- SCF(US) trains TBAs in ante-natal care
- Futures/CRS sponsors the social marketing of clean delivery kits
- CEDPA focuses on expanding access and the delivery of quality health services and health information, promotes safe delivery kits, family planning and the empowerment of women
- JHUPCS develops radio education programmes for health professions and IEC messages through radio “soap operas” on family and reproductive health.

However, little attention has been paid by any of the above to the role of the district hospital in reducing maternal mortality. NSMP collaborates with some of these organisations but remains the only project to have a specific EmOC focus.

WHY DOES NSMP FOCUS ON IMPROVING EMERGENCY OBSTETRIC CARE TO REDUCE MATERNAL MORTALITY?

The maternal mortality ratio (MMR) in Nepal is amongst the highest in the world. Estimates range from 539 - 1500 women per 100,000 live births¹. Maternal mortality accounts for over 20% of deaths amongst women of reproductive age in Nepal, more than any other single health problem.

World-wide, five causes account for 73% of maternal deaths. These causes are haemorrhage (25%), infection (15%), hypertension and eclampsia (12%), unsafe abortion (13%) and obstructed labour (8%). Other causes such as anaesthetic-related deaths, ectopic pregnancy and embolism account for the remaining 27% of maternal deaths.

Since the global Safe Motherhood Initiative was launched in 1987 strategies to reduce maternal mortality have had a broad focus encompassing family planning, ante-natal care, clean/safe delivery through TBAs, essential obstetric care, basic maternity care, primary health care, and equity for women². However, these strategies have had little impact on reducing the maternal mortality ratio and it is now recognised that only access to EmOC can substantially reduce maternal mortality.

Only emergency obstetric care includes activities which can substantially reduce maternal mortality³.

There are two major misconceptions about how maternal mortality can be reduced. One is that improvements in women's socio-economic development will lead to a reduction in maternal mortality. Evidence shows this is not true. In Britain, despite rising living standards, maternal mortality was only dramatically reduced from 1930s onwards when the technology to treat obstetric emergencies became available - antibiotics to treat infection, adequate blood supplies and improved surgical procedures for caesarean deliveries.

A second misconception is that ante-natal care can lead to early detection and treatment through screening for risk factors. Research does not support this approach since most obstetric complications can neither be predicted nor prevented. Screening for risk factors⁴ can identify groups of

¹ Nepal Family Health Survey, 1996, Family Health Division, HMGN.

² World Health Organization, *Mother-Baby Package: A Road Map for Implementation in Countries*. WHO, 1993.

³ Maine D and Rosenfield, Allan, *The Safe Motherhood Initiative: Why has it Stalled?* American Journal of Public Health, April 1999, Vol.89, No 4.

women at “high” and “low” risk. It cannot predict which women in these groups will experience complications and possible death.

Whilst obstetric emergencies cannot be prevented nor predicted they can be treated. Therefore a more successful strategy is to assume that all pregnant women are at risk of obstetric complications and to focus on providing emergency obstetric services of good quality which are accessible and used by women when needed.

The above argument provides the rationale which underpins the Nepal Safer Motherhood Project.

WHAT IS THE DIFFERENCE BETWEEN BASIC AND COMPREHENSIVE EMERGENCY OBSTETRIC CARE?

Emergency Obstetric Care is divided into Comprehensive and Basic which have accepted definitions (see table below).

Basic EmOC Services	Comprehensive EmOC Services
<ol style="list-style-type: none"> 1. Administer parenteral* antibiotics 2. Administer parenteral oxytocic drugs 3. Administer parenteral anticonvulsant 4. Perform manual removal of the placenta 5. Perform removal of retained products of conception 6. Perform assisted vaginal delivery 	<ol style="list-style-type: none"> (1-6) All of those included in BEmOC 7. Perform surgery (caesarean section/laparotomy) 8. Perform blood transfusion
<p>A Basic EmOC facility is one that is performing all functions 1-6</p>	<p>A Comprehensive EmOC facility is one that is performing all functions 1-8</p>
<p>*parenteral administration of drugs means by injection or intravenous infusion ‘drip’</p>	

Minimum acceptable coverage is stated to be: for every 500,000 people there should be one facility providing CEmOC and four providing BEmOC⁵.

⁴ Risk assessment is a tool used by health systems that aims to separate women into categories typically “high” and “low” risk according to certain social, demographic or physical characteristics such as educational status, age, height and number of pregnancies.

⁵ From “Guidelines for monitoring and availability and use of obstetric services” UNICEF, WHO, UNFPA 1997

In Nepal access to these services, even if available, is complicated by issues of gender, inequality, poverty and difficult terrain. Three “delays” have been identified as barriers to receiving appropriate care:

- delay in seeking EmOC due to lack of awareness of danger signs, prevailing attitudes to pregnancy, and lack of a referral system.
- delay in reaching an EmOC facility due to lack of money, inadequate transport systems and difficult terrain.
- delay in actually receiving care after arriving at a facility .

Whilst the project is working to address all three delays the focus of this booklet is on the project approach and strategy to the third delay, that of receiving care at an EmOC facility.

WHAT IS THE CURRENT ORGANISATIONAL CULTURE IN NEPAL?

“Over the last 30 years, Nepal has received billions of dollars in aid and loans, employed thousands of foreign experts, and the best and most educated minds in the country. Yet, in the assessment of many Nepalese and Westerners, Nepali state organisations and institutions, are very ineffective, unproductive, impervious to improvements, autocratic, rigid and unresponsive to customer needs and satisfaction”.

Ravi Pradhan: The Jagir Culture in Nepali Organisations: an essay in the Kathmandu Post, 1993

The historical roots of the Jagir culture lie somewhere in the 16th and 17th Moghul regimes. In this system the ruler appointed loyal subjects as jagirdhars (feudal lords) over a jagir (fiefdom). The jagirdhar was the absolute ruler of his fiefdom in which productivity, efficiency, quality of product or service, innovation or creativity, merit and hard work were not rewarded but suppressed. After 1950 some argue that the various ministries and departments became the new jagirs.

The consequences of this system can be seen in current management practices:

- in recruitment and hiring, personal connections are the key to being recruited.
- transfers and promotions are made as a show of power and not based on any transparent criteria or need.
- there is a limited concept of responsibility and accountability - job descriptions are mostly lists of things to do with no evaluation of performance.
- rules and regulations are written and manipulated by bureaucrats to maintain control. A Nepali saying goes “the bureaucrat is skilful at manipulating his pen” (kalam ghumaune).

- there is no incentive to save costs, improve quality of service, to design innovative products, to work as a team, to increase skills or address customer satisfaction.

“Probably the most devastating effect of the Jagir culture is that it has disabled people in their capacity to create new possibilities, new visions, and to take responsibility for creating and initiating changes.”

Ravi Pradhan: The Jagir Culture in Nepali Organisations: an essay in the Kathmandu Post, 1993

Attempts have been made to make recruitment, posting and promotion of staff more transparent. The Public Service Commission was established forty years ago, and had responsibility for selecting staff for public sector posts. A system for selection was developed. However, this authority was delegated to the MOH until recently. In 1998, the Health Act made explicit policy for grading and promoting health staff of all levels. An expected minimum time to be spent working in remote areas prior to promotion and/or further education has been specified. However, this is still not in full operation.

A common understanding amongst the Nepalese is that “your future is already written down for you - it is your karma or your fate”. Consequently many employees in government organisations are immersed in a mood of cynicism and apathy - “ke garne” or “don’t give yourself a headache because nothing can change”.

It is in this context of despair and cynicism in government hospitals that NSMP began its efforts to support fundamental changes in the way services were delivered.

WHAT IS THE VISION, PHILOSOPHY AND APPROACH OF NSMP?

Vision of NSMP

By the end of the inception phase NSMP had developed a clear vision for the project.

VISION OF NSMP

By the end of Phase One the three district hospitals will be able to offer 24-hour Comprehensive Emergency Obstetric Care in an environment which is:

- **safe and clean**
- **adequately equipped**
- **woman and family-focused**
- **staffed by personnel who are committed to working as a team to improve maternal health**
- **managed by staff confident and competent to treat obstetric emergencies appropriately**

This was not only the **vision** but also the **challenge** for the project.

In order to meet this challenge NSMP recognised that fundamental institutional transformation would be required within the project hospitals. The prevailing culture within health services in Nepal was antagonistic to and sceptical of current training approaches. The concepts of quality of care and client-focus were not well understood nor emphasised. NSMP needed to develop activities and strategies which would ensure that the systems to support and sustain improvements in the quality of EmOC services were in place and functioning well.

Philosophy of NSMP

To meet this challenge the NSMP project team drew strength from a philosophy grounded in the belief that people are capable of change, growth and adaptation; that people want to learn, want to work with change and to contribute to the institution in which they work. What would be essential to achieving success would be the development of an approach which would unlock these attributes within hospital staff rather than attempt to impose them.

Approach of NSMP

To develop and nurture the desired change in hospital staff NSMP devised a capacity building approach which went far beyond the commonly used training model.

The key elements of the approach are:

- development of basic structures - buildings, equipment and supplies.
- training of all staff (including peons, sweepers and support staff) according to needs identified with staff.

- setting of realistic standards by staff themselves.
- facilitating and supporting change by posting Human Resource Development Officers (HRDOs) to the hospitals.
- developing a team approach to finding solutions using the COPE model.
- monitoring improvements in quality on a quarterly basis.

Within each of the key elements of this strategy numerous initiatives were implemented. The purpose of this document is to analyse the lessons which can be drawn from the implementation of these initiatives and to share them with a wider audience than NSMP.

WHAT ARE THE KEY ELEMENTS IN NSMP'S APPROACH TO IMPROVING EMERGENCY OBSTETRIC CARE IN HOSPITALS?

The design and conduct of a needs assessment was the first element in NSMP's approach. The results of the needs assessment determined the inputs and activities required and was vital in beginning to establish relationships and sharing between hospital and project staff.

NEEDS ASSESSMENT

The first step taken during the Inception Phase of the project (March to December 1997) was to conduct a hospital needs assessment. A needs assessment had been carried out in the project formulation stage, but this needed further development as it was limited in scope.

The aim of the Inception Phase needs assessment was to identify the current level and quality of emergency obstetric care (EmOC) activities within the first phase districts of Baglung, Surkhet and Kailali. The needs assessment team also investigated the contextual factors affecting the level and quality of care that the hospitals are able to deliver.

Although EmOC was the primary focus of the needs assessment, this could not be assessed in isolation as it is part of the system of maternal care as a whole. The needs assessment therefore addressed the quality of reproductive health care available within the hospital and at District Public Health Office (DPHO) ante-natal clinics.

The team of surveyors developed the tools and undertook the assessment with the following objectives:

- to identify the current level of EmOC provision and performance.
- to gather baseline data on the elements of quality of care.

- to identify individual staff training needs.
- to identify contextual factors other than training that may influence staff performance levels.

The most difficult task was to assess quality of care since definitions and perceptions of quality vary. The WHO's Mother and Baby Package (1994) specifies the elements that make up quality of care for safe motherhood. These elements were used as the basis of the needs assessment and have since been adapted to the local context as the basis for monitoring quality of care. A fuller version can be found in the Useful Tools Section at the back of this booklet.

WHO ELEMENTS OF THE QUALITY OF MATERNAL HEALTH CARE

- **Promotion and protection of health**
- **Accessibility and availability of services**
- **Acceptability of services**
- **Technical competence of health care providers**
- **Essential supplies and equipment**
- **Quality of client-provider interaction**
- **Information and counselling for the client**
- **Involvement of client in decision-making**
- **Comprehensiveness of care and linkages to other reproductive health services**
- **Continuity of care and follow up**
- **Support to health care providers**

Developing the Needs Assessment Tools

Quality must be judged by comparing performance or achievement against established standards. The standards used to develop the needs assessment were from a number of sources including WHO⁶ and the Population Council⁷.

Methods of Data Collection

The needs assessment team consisted of the NSMP Technical Training Adviser, who acted as co-ordinator, a management expert, an obstetrician and nurse/midwife. The team spent one week within each of the hospitals observing care, talking to staff and clients.

⁶ WHO 1995, *Safe Motherhood Needs Assessment*, WHO/FHE/MSM/95.1

⁷ Population Council, 1996, *Critical Issues in Reproductive Health: Situation Analysis of Obstetric Services*.

The following tools were used:

- ***A hospital management profile for each district***
This tool was developed to give an overall view of the hospital management, range of services and utilisation of facilities.
- ***Client interviews - ante-natal and postnatal exit***
Interviews were carried out with clients to gauge their perceptions in relation to the services provided.
- ***Case/incident reports***
Surveyors documented any 'critical incidents' they observed. These incidents were used to illustrate the needs assessment findings with actual events that took place.
- ***Photographic evidence - facilities, equipment***
To illustrate the conditions within the hospital.
- ***Delivery and client records***
To collect data on the patient flow and the type of obstetric emergencies the hospital staff are caring for.
- ***Non-participant observation***
Client care and EmOC skills were observed using competency-based checklists.
- ***Health care provider knowledge questionnaires***
Questions were asked in relation to the 5 major obstetric emergencies.
- ***Individual client tracking***
From admission the client was followed in order to ascertain the time when they were seen by an appropriate service provider, when treatment was given, and/or referral made.
- ***Personal analysis***
85 questionnaires were completed with staff at every level of the hospital system to elicit individual staff's perception of their own performance, previous training, qualifications, experience, current post, future aspirations and career prospects.

Whilst the needs assessment was being conducted an architect and hospital equipment specialist conducted a detailed assessment of physical facilities and equipment needs.

Once the needs assessment had been completed and the results analysed, workshops were held in the three districts to share the findings and develop an action plan. All grades of hospital staff were involved.

As a consequence of these workshops the separate needs which had been identified were seen to fall into a pattern as shown in the diagram below. The

needs assessment identified two umbrella needs - advocacy to promote EmOC, and a contracting process to contract all the required inputs.

Other needs identified fell into three areas:

- capacity-building needs - to improve overall job performance
- infrastructure needs - to improve facilities and equipment
- motivational needs - to empower staff to make changes



What lessons were learned from this needs assessment?

LESSONS LEARNED

- **an effective needs assessment needs time to design appropriate tools, conduct the assessment, and analyse the results**
- **a needs assessment gives the opportunity to start building relationships with hospital staff**
- **sharing the results with hospital staff and working together to identify inputs will promote ownership and ensure relevance of inputs to staff's perceived needs**
- **choose the season carefully - monsoon season is not the ideal time**
- **local consultants may have limited experience in conducting such needs assessments and will need training - but they do provide an invaluable local perspective**
- **the needs assessment process is part of the change strategy and thus participation by stakeholders is essential**

The needs identified in the needs assessment are described in more detail below.

THE NEED FOR ADVOCACY

Previous activities to address maternal mortality have emphasised ante-natal care and training of TBAs and not EmOC. Further, HMGN policy allowed only doctors, not nurses and paramedics, to administer life-saving skills even though qualified doctors are frequently not available in hospitals. There is no consensus on what different hospital cadres are allowed to do in relation to EmOC. NSMP saw there was a need to raise the profile of EmOC amongst donors, government, NGOs and doctors, and to initiate and support efforts to clarify and change government policy.

NSMP met the challenge of raising the profile of these issues by working with like-minded organisations and individuals, by attending numerous meetings, and by networking with key agencies. Further, considerable time and effort was invested in assisting in the HMGN-FHD Maternal Mortality Study and in the field-testing of newly-created reproductive health protocols. The development of these protocols, sponsored by UNFPA, necessitated definition of the roles of different cadres in relation to reproductive health. This was a major breakthrough. It is likely that nurses will officially be able to carry out life-savings skills in the near future.

As a consequence of these advocacy activities NSMP is now regarded as a player with credibility because of the sound field experience of the NSMP team. EmOC has a higher profile and policy changes are likely.

What lessons can be learned about advocacy ?

LESSONS LEARNED

- actively seek to form coalitions with other agencies with the same vision
- be willing to get involved in all reproductive health issues
- have sound field experience to achieve credibility
- be aware that donors can have different agendas and time scales to yours
- be prepared to invest considerable time and effort

THE NEED TO CONTRACT SERVICES

NSMP recognised that they would not be able to conduct the training identified in the needs assessment themselves. They also recognised that renovation and reconstruction work, as well as the purchase of supplies and equipment, would have to be contracted out to other organisations. As no appropriate written contract procedures existed, NSMP sought the advice of DFID financial advisers and developed appropriate forms and systems. A Contracts Manager was appointed to manage the process.

The process has now been refined and the key points are described overleaf.

The NSMP contracting process

1. Development of Terms of Reference which give the background to the project and describe the philosophy of NSMP, required input, expected outputs and time schedule

2. Identification of potential contractors, discussion of ToRs, and clarification of issues

3. Negotiation and preparation of contract with statement of phased payments

4. Agreement on schedule with stakeholders (e.g. hospital managers and staff)

5. Back-stopping by NSMP of contractors to build their capacity

6. Monitoring of quality and follow-up

7. Evaluation of input

What lessons can be learned about contracting services?

LESSONS LEARNED

- develop contract forms and processes appropriate to your needs
- be prepared to assist contractors to complete and submit invoices
- make no assumptions about the capacity of organisations who tender for the contract - they often have a lower capacity than expected
- be prepared to spend time in supporting contractors to increase their own capacity
- monitor the quality of the work closely
- ensure contractors are aware of and willing to comply with project philosophy and norms

THE NEED FOR CAPACITY-BUILDING ACTIVITIES

The needs assessment and discussions with staff in the districts identified low capacity in a number of areas:

- **infection prevention and waste management** - weak understanding of infection prevention procedures and their importance in protecting patients and staff.
- **basic midwifery care** - little routine monitoring and care was carried out and there was an inability to take action when a problem was identified.
- **ante-natal care and the referral system** - women attending ANC were not referred on discovery of a problem, and no information was given to women on the danger signs of an obstetric emergency.
- **neo-natal care** - quality of care was very low, with weak knowledge of resuscitation methods.
- **post-abortion care** - no knowledge or skills in Manual Vacuum Aspiration and no counselling was given in family planning after abortion procedures had been carried out.
- **BEmOC and CEmOC** - doctors were not skilled in performing caesarean sections, staff had weak knowledge and skills in BEmOC.
- **attitude to communication** - staff rarely gave explanations to patients, and were often rude.
- **management systems and skills** - supervision lacking or punitive, pervading sense of hopelessness, no guidelines for procedures.
- **provision of safe and adequate blood supplies** - blood was not tested for HIV and Hepatitis B, and supply was often inadequate or unavailable.
- **management and maintenance of stores** - no proper system was operating.

NSMP recognised that many of these areas were strictly outside the focus of the project. However, the project's goal was unlikely to be achieved if these were not addressed.

NSMP contracted a series of capacity-building inputs to address the identified weaknesses.

INFECTION PREVENTION

Training in infection prevention and waste disposal was contracted to the Nepal Fertility Care Centre and included a 7-day training for nurses and doctors and a 5-

day training for peons and sweepers. All training took place on-site. NFCC Field Officers provided monthly follow-up for 12 months. Supplies for infection prevention were provided by NSMP.

As a result an Infection Prevention Committee has been established within each hospital with representation from all cadres. The Committee monitors the situation within the hospital and finds solutions to problems. Hospitals are safer and cleaner and both staff and patients are better protected.

MIDWIFERY SKILLS

Four nurses from each district attended midwifery training at Patan Hospital in Kathmandu for six weeks. Trainee staff developed objectives for change on return to their workplaces. The training was followed up by visits to each hospital and additional coaching by both staff of the Patan Hospital and project staff.

As a consequence the partograph has been introduced and adapted to local circumstances and is now in use in all three hospitals. The trained staff regularly train and update other staff. Audit of the partograph takes place regularly and has developed into an audit of care with discussions about why actions were or were not taken.

The midwifery training course has proved very popular with staff and, due to demand, continues to be offered by Tansen Hospital in Palpa district. The popularity of the course is attributed to the skills-based emphasis and the course's relevance to the clinical situation.

ANTE-NATAL CARE AND THE REFERRAL SYSTEM

Two ANC nurses attended the midwifery training contracted to Patan Hospital. ANC staff in all three districts attended the various NSMP training courses and are involved in the Quality of Care monitoring systems. Orientation was provided in Baglung for ANC staff in the diagnosis and syndromic treatment of STD. It is planned to extend this to the other two districts.

As a consequence referrals are now made to other services and registers kept. Protocols have been developed for ANC visits which specify what activities should take place at each visit including when action should be taken to refer. Clients are now more likely to receive a comprehensive service of ante-natal/post-natal care, STD diagnosis and treatment, as well as health education and individual counselling.

NEO-NATAL CARE

Training in neo-natal care was contracted to Mother Infant Research Activities (MIRA). On-site training was conducted for peons, sweepers, doctors and nurses. (note: peons and sweepers carry out most of the usual neo-natal care). MIRA

provided two day's follow-up in each district. Nurses attending the midwifery training at Patan Hospital also received training in neo-natal care.

As a result of this training there is improved use of the Apgar score to determine action needed, resuscitation now takes place sooner, equipment is cleaner, babies are kept warmer and given to mothers to breast-feed earlier. Protocols have been developed by staff for care of new-born babies.

POST-ABORTION CARE SERVICES

Training in Post Abortion Care (which includes the use of Manual Vacuum Aspiration rather than Dilatation and Curettage, and counselling in family planning) was undertaken in collaboration with JHPIEGO and the NHTC even though, initially, these services were planned by HMNG solely for regional and zonal hospitals. The Director of the Family Health Division gave permission for hospital staff nurses to be trained as providers of the service. Previously, only medical practitioners were provided with this training.

PAC services have now commenced and registers have been designed and are in use in two hospitals.

PROVISION OF BEmOC AND CEmOC

Patan Hospital has trained one project district doctor for three months though he is not yet confident enough to perform caesarean sections. A further doctor has been offered the same training. Two doctors have been offered scholarships by NSMP to study for a Diploma in Obstetrics and Gynaecology.

Though CEmOC is available at two of the project hospitals, it is not a 24-hour service and is not provided at all when the doctor is absent. In the third hospital, where there is no surgeon, a referral system to the Western Regional Hospital has been established and is working well.

Meanwhile nurses have been trained to provide BEmOC and are providing an appropriate service - even though this is against current government policy. As long as doctors are posted inappropriately and frequently there will be little likelihood that the three district hospitals will be able to provide an adequate CEmOC service.

CHANGING ATTITUDES TO COMMUNICATION

SCF(UK) was contracted to provide training in communication skills for **all** staff, including peons and sweepers. A two-day follow-up was provided and an evaluation carried out six months after the training.

Communication has improved, both with patients and with other hospital departments. Patients are now given explanations about procedures during delivery, and explanations are given when medicine is dispensed. Guidelines have been

developed for counselling patients on exit from maternity about personal hygiene, nutrition, family planning etc. Most staff appreciate that they have a role in assisting patients to find their way around the hospital rather than ignoring them.

There is evidence of improved communication between departments. For example, guidelines have been developed by the Hospital Management Committee, the laboratory, registration, ANC and the maternity unit to improve the system for obtaining clinical tests and results by maternity clients.

Communication has also improved between the hospital and the community, although there remains a deep divide.

MANAGEMENT FOR CHANGE SKILLS

Karuna Management, a Nepali company, was contracted to provide a Management and Team Effectiveness Programme for the clinical, support and administrative staff of the project hospitals. This programme took place over ten months in two of the hospitals (the third hospital was scheduled to receive management training from the DFID-funded District Health Strengthening Project and so was not included). The same company was also contracted to provide a Facilitation Skills (also known as Change Agent) course for internal coaches (those people who would have the task of supporting hospital teams to sustain their learning after the training).

A third training input by Karuna Management was an Effective Manager Course for key district level people, particularly from the district excluded from the first training.

The training has had significant impact. Team-working has improved, supervision and appraisal is becoming supportive rather than punitive, and training needs are identified and met by staff themselves.

However, the most important result of this training has been evidence of the change in management culture rather than in systems. This is described in more detail in the section on the motivation needs of hospital staff.

PROVISION OF SAFE AND ADEQUATE BLOOD SUPPLIES

Note: blood is collected and supplied by the Blood Transfusion Service which is managed by the Nepal Red Cross. This service is physically and managerially separate from the district health service.

Red Cross staff were included in all on-site training provided by NSMP. The National Blood Transfusion Service (NBTS) provided refresher training for Red Cross technicians and follow-up on-site. A one year training was provided in Kathmandu for technicians from each project district. Financial support to begin a revolving fund for purchasing testing kits was provided by NSMP. Regular monitoring of the system is carried out by the HRDOs and central level Red Cross.

The situation is much improved. Blood is safe and provided when requested. Communication has improved between hospital staff and the Blood Transfusion Service, but there is some way to go before the system is 100% reliable.

MANAGEMENT OF STORES

Management Support Services (MASS) were contracted to auction old, unused equipment which was littering store-rooms. John Snow International (JSI) provided on-site coaching for store-keepers. All store managers attended on-site training in infection prevention, communication and management. NSMP provided new shelving and a new store in Kailali. Work is underway to develop pictures which will help store-keepers identify unfamiliar complex equipment. HRDOs and the NSMP Contracts Manager monitor the situation regularly.

Stores have been re-organised and items labelled. There is improved communication between stores and other departments. In Surkhet wards keep one month's supply of drugs on the ward and replenish when necessary. However, HMGN rules and regulations in relation to supplies are complex and, at the moment, there is little chance that store managers will be able to properly manage stores (i.e. estimate need for drugs and supplies in advance).

What lessons can be learned from the capacity-building activities?

LESSONS LEARNED

- **Training should:**
 - **be provided in response to needs identified *with* hospital staff**
 - **be provided *on-site* where appropriate**
 - **be provided for the *whole-team* where appropriate**
 - **be followed up by additional coaching and support by HRDOs and trainers**
 - **incorporate tasks and objectives for staff to implement after training e.g. breakthrough projects developed by the staff team themselves**
 - **be given to a *critical mass* to protect "the change" from the effects of frequent staff moves**
- **quality of training conducted by sub-contractors should be *ensured* by briefing of contractors in NSMP's philosophy, clear ToRs for the training task, monitoring and evaluation of the training**
- **acceptance that contracted training organisations may need considerable "back-stopping" due to relatively low capacity**
- **a combination of inputs is necessary - e.g. reconstruction of buildings, provision of supplies and equipment, support of "change-agents" as well as training. Training alone will not succeed, nor will simply providing supplies.**

THE NEED FOR RENOVATION OF INFRASTRUCTURE

The buildings and the equipment in the hospitals were totally inadequate for the provision of EmOC. The original project design had not discovered the severity of the situation and this item was under-budgeted in the design. Re-allocation of the budgets was needed in order to commission the work needed.

RENOVATION AND MAINTENANCE OF BUILDINGS

The situation in all three hospitals was desperate. In Surkhet there was no maternity ward and patients and new-born were accommodated in the general ward alongside infectious patients. In Kailali sewage backed up through the hospital corridors and mosquito netting became “live” during rain storms due to poor electrical earthing. None of the hospitals had proper provision for waste disposal. The electricity and water systems in all three hospitals operated only intermittently.

NSMP contracted a consultant architect to design new operating theatres, re-construct existing buildings and to oversee building contractors. The work is to a high standard and the new facilities are on target to be operational by July 1999.

New concrete waste pits were constructed at each hospital to provide sufficient capacity for five years.

The project cannot address all problems resulting from poor basic systems in the hospitals. However, with the financial support of the Technical Assistance Programme of the International Nepal Fellowship (INF-TAP), major electrical improvements are being made in Kailali without which the functioning of the new maternity unit would be compromised.

This work has been running side-by-side with the capacity building activities and has provided a significant boost to the morale of the staff. Importantly, staff have been involved in the design and in preparation for all stages of building and commissioning.

PROVISION OF MEDICAL EQUIPMENT AND SUPPLIES

Most equipment in the hospitals was of poor quality and not working. Essential drugs were not available. Laboratories were very basic with a low capacity to undertake essential basic tests. Very few cleaning materials were available.

NSMP contracted a consultant to draw up an inventory of necessary equipment. This inventory was discussed with hospital staff and amended according to their suggestions. A local procurement agent, Medical Supplies Department, (a department of INF-UMN) was contracted to procure local equipment (i.e. from Nepal and India). This required permission from DFID to bypass normal procurement procedures. INF-TAP was contracted to be quality assessors for equipment procured by MSD.

INF-TAP included hospital peons in their regular training programmes on hospital maintenance. Nursing staff developed a system whereby a supply of essential drugs is maintained in each delivery room to avoid delays in provision.

Other than provision of lab sticks by NSMP, problems with laboratories were not addressed. Improvements were seen to be too large a task to be included in NSMP.

All these activities are on-going and are not yet fully functional.

What lessons can be learned from infrastructure activities?

LESSONS LEARNED

- **specify clearly what the project can do and what it cannot do - there can be many requests to solve other hospital problems**
- **where possible purchase local equipment - European equipment cannot be repaired easily and is too complex**
- **involve all hospital staff cadres in selecting equipment and supplies and in finalising facility improvement designs**
- **include the testing of equipment (not just assessing the outer appearance) in the contract for the quality checking of purchased equipment**
- **encourage co-operation between hospital staff and building contractors and procurement agents**

THE NEED TO IMPROVE MOTIVATION OF HOSPITAL STAFF

NSMP knew from the beginning that unless the spirit of hopelessness that prevailed in the project hospitals was changed, the project would have little chance of achieving its goal.

Staff had little interest in their work, were apathetic to problems and finding solutions, had unrealistic expectations of donor-led projects, did not have a team-working approach, and regarded training as a perk and not of value to their jobs.

NSMP pursued a deliberate strategy to address these problems.

- The most significant element of the strategy was the appointment of three Human Resource Development Officers. The HRDOs were posted within each hospital and their task was to support, motivate and coach hospital staff, particularly after training inputs. NSMP made sure the HRDOs were competent at any task by providing them with appropriate training (e.g. a month's training at Patan Hospital

in the use of the partograph, training in PAC services) in advance of hospital staff training. They are also responsible for monitoring the quantity and quality of improvements taking place in the hospitals and reporting back during their monthly visits to the NSMP office in Kathmandu.

Hospital staff acknowledge readily that, without this input from the HRDOs, the training they have received would probably not have led to any change in working practices.

Other elements in the approach to improve motivation included:

- delivering on the promises made to districts.
- including all cadres in planning activities.
- having clear boundaries around what NSMP will deliver and what it will not.
- having no hidden agendas - what the HRDOs know is what hospital staff also know.
- attaching no blame to current work performance, but celebrating what staff have achieved in difficult circumstances.
- ensuring training in the project is designed to meet identified staff needs.
- identifying and nurturing key players within the hospital who can carry on the motivation after NSMP leaves.
- creating a scholarship fund for individuals to undertake relevant training courses. This is intended to develop local capacity and to contribute to sustaining project activities. It is available to local people who would not normally have access to such sponsorship (e.g. one peon in Baglung is currently undertaking training as an Auxiliary Nurse Midwife).
- establishing a Merit Award Scheme - to be awarded to hospital teams (not individuals) for some aspect of the hospital's Quality of Care programme (e.g. infection prevention).
- introducing the COPE approach to develop a "no blame, team solution-seeking" approach.
- protecting against de-motivation by allowing staff to set their own standards and pace and work towards achieving National Standards - rather than impose National Standards.
- establishing the importance of record-keeping and monitoring systems to show improvements in quality of care due to staff performance.

- realising that there needs to be a degree of flexibility in implementing plans to account for changing circumstances.

Of particular importance in this motivation process was the contribution made by the “management for change” input which sought not to change management systems, but the management culture. Weaknesses within the health sector were placed within the context of the Nepali management culture. A solution-seeking approach was demanded of hospital staff as well as a deep commitment to their work.

The administrator in one hospital stated: “I have been here for 26 years and I thought I was top dog and very important - now I feel I am no better and no worse than a peon. For the first time I am able to contribute positively to the improvement of the hospital”.

The change in attitude and motivation amongst the hospital staff is remarkable. Staff now identify “breakthrough projects” and work in teams to find solutions to problems. So far they have developed their own training packages, adapted protocols for local use, established action groups, set up emergency drug supplies in delivery rooms, set up Infection Prevention Committees with representatives of all cadres etc. In one district the DHO “walks the talk” by cleaning his own section of the hospital grounds and, in so doing, sets an example to all hospital staff - previously this would never have happened.

What lessons can be learned about activities to improve motivation?

LESSONS LEARNED

- **staff motivation is an essential ingredient in any project - without it little will be achieved, however substantial the other inputs**
- **motivation can be achieved without financial rewards to staff**
- **a strategy must be developed to achieve staff motivation, and not left to chance**
- **key figures must be identified amongst hospital staff to sustain motivation after the end of the project**
- **identify an “early win” - an activity which affects all staff and has immediate benefit e.g. infection prevention control and waste management**

CONCLUSION

This document has given a broad picture of how NSMP has faced the challenge of improving EmOC from the service provision side. In the beginning no-one anticipated

the number of problems which would need to be addressed nor the effort and commitment required to do this.

Many other activities have taken place, but they are too numerous to record here. One might be forgiven for thinking that the project proceeded logically from one step to another. This was not the case as so many activities were taking place simultaneously. However there has been a logic underpinning the project activities and this booklet has tried to extract this logic and present it in a way which will, hopefully, be of use to others.

USEFUL TOOLS

The COPE Approach

WHO elements of the quality of maternal care

Quality of care, its determinants and service effects

An introduction to the COPE approach

COPE stands for “Client-Orientated Provider-Efficient”. The COPE approach was pioneered by AVSC to improve the quality of family planning activities. NSMP have adapted this approach for use within project hospitals.

The adapted COPE approach has several steps:

- 1. Self assessment is carried out by hospital staff in a number of areas relating to quality (e.g. relationships between client and service provider, technical skills etc). These areas relate to the objectives set by staff after each training intervention in the project. Clients’ views should also be sought. At the moment staff do not do this, but will be encouraged to do so in the future.*
- 2. Staff then examine the results of the self assessment and identify areas for development or where problems need solutions.*
- 3. Staff examine the causes of the problem and discuss possible solutions.*
- 4. An action plan is made and responsibilities assigned.*
- 5. The plan is monitored and evaluated to assess its effectiveness.*

The COPE approach emphasises team working, a “no-blame” environment, involvement of clients, and a willingness by managers to relinquish absolute control over all processes.

WHO ELEMENTS OF THE QUALITY OF MATERNAL HEALTH CARE⁸

- **Promotion and protection of health**

People need to know about pregnancy and childbirth and to understand the danger signs and symptoms.

- **Accessibility and availability of services**

Women should be able to benefit from quality of care, understand the full range of services available to them and receive care at the lowest appropriate level of the system close to where they live.

- **Acceptability of services**

Women need privacy, they may prefer to consult a female health worker, and they should be assured of confidentiality.

- **Technical competence of health care providers**

Technical competence depends on regular training and retraining, and on clear guidelines for clinical treatment.

- **Essential supplies and equipment**

Norms and standards should be established for the necessary supplies and equipment at each level of care and their availability should be ensured.

- **Quality of client-provider interaction**

Providers must treat clients with respect, be responsive to their needs and avoid judgmental attitudes.

- **Information and counselling for the client**

Clients should have the opportunity to talk to health care providers and should be offered guidance on any health problems identified.

- **Involvement of clients in decision making**

Providers should see clients as partners in health care and should involve them in decision-making as active participants in their own health care.

- **Comprehensiveness of care and linkages to other reproductive health services**

Maternal health care is a unique opportunity to provide women with comprehensive reproductive health care and to address issues such as nutrition and sexually transmitted diseases.

- **Continuity of care and follow up**

Maternal health care should be part of a continuum of care comprising pre-pregnancy, prenatal, delivery and postpartum care. Clients must be seen as people with health needs that continue throughout their lives.

- **Support to health care providers**

Health care providers at all levels need the back-up and economic and social support of the authorities and the communities in which they work.

⁸ WHO, 1994, *Mother-Baby Package: Implementing Safe Motherhood In Countries* (WHO/FHE/MSM/94.11), Geneva: WHO.

QUALITY OF CARE, ITS DETERMINANTS AND SERVICE EFFECTS

Contextual factors →→→→→→→→ Service characteristics →→→→→→→→ Quality of care →→→→→→→→ Service effects

CONTEXTUAL FACTORS

SAFE MOTHERHOOD

- Hospital management system
- Political and administrative systems
- Profession roles/culture
- Social, cultural and economic structure

SERVICE CHARACTERISTICS

- Staff characteristics
- Staff training
- Staffing levels
- Work effort/motivation
- Hospital environment
- Supervision/leadership
- Logistics and supplies

QUALITY OF CARE

- Promotion and protection of health
- Accessibility and availability of services
- Acceptability of services
- Technical competence of health care providers
- Essential supplies and equipment
- Quality of client-provider interaction
- Information and counselling for the client
- Involvement of client in decision-making
- Comprehensiveness of care and linkages to other reproductive health services
- continuity of care and follow up
- Support to health care providers

SERVICE EFFECTS

- Use of services
- User satisfaction
- Safer motherhood

*Adapted from a table by Ruth Simmons and Christopher Elias
The Study of Client-Provider Interactions: A review of Methodological Issues
Studies in Family Planning, Vol.25 No 1
Jan/Feb 1994*